Legislative Workgroup on Electronic Prescribing

Report to 2012 Louisiana Legislature

In Response to

HR 108 & SR 81 of 2011 Louisiana Legislature

February 1, 2012

I. Legislative Resolutions

Senate Resolution 81 (Senator Mills) and House Resolution 108 (Representative LeBas) created the Legislative Workgroup on Electronic Prescribing.

A. Purpose

The resolutions charged the workgroup to study and make recommendations to the legislature concerning electronic prescribing which at a minimum would accomplish and/or address the following:

1. Seek to limit marketing in electronic health record systems.
2. Seek to encourage the provision of evidence-based information at the point of care for the prescriber and patient.
3. Standardize prior authorization to maximize administrative simplification and efficiency and adopt a universal prior authorization form to be made available for electronic use.
4. Provide for a patient's freedom of choice with respect to the selection of a pharmacy.
5. Provide for user authentication, audit, and physical security.
6. Best practices to maintain a neutral platform for the secure electronic transmission of health data, including but not limited to medication history, formulary status, and other patient information health professionals typically access when prescribing medication and other interventions.
7. Best practices to assure attempts to influence, through economic incentives or otherwise, the prescribing decisions of the practitioner at the point of care can be kept to a minimum and focused on patient safety and outcomes that maximize patient and provider freedom of choice.
8. Best practices to assure messages in electronic prescribing systems are substantially supported by scientific evidence, accurate, up to date, and fact based, including a fair and balanced presentation of risks and benefits, and support for better clinical decision making, such as alerts to adverse events and access to formulary information.

9. Best practices to establish a process to provide electronic prior authorization request and approval transactions between providers and group purchasers.

B. Membership

The resolutions identified the members of the workgroup as one representative from each of the following organizations:

1. Louisiana Board of Pharmacy, who will serve as co-chair
2. Louisiana Board of Medical Examiners, who will serve as co-chair
3. Department of Health and Hospitals
4. Department of Insurance
5. Louisiana State Medical Society
6. Louisiana Academy of Family Physicians
7. Louisiana Independent Pharmacies Association
8. Pharmaceutical Researchers and Manufacturers of America
9. Louisiana Association of Health Plans
10. Louisiana Health Care Quality Forum
11. Louisiana Hospital Association
12. Louisiana Workers' Compensation Commission
13. Louisiana Association of Self Insured Employers
14. eQHealth Solutions
15. National Association of Chain Drug Stores
16. Louisiana Orthopedic Association
17. Louisiana Board of Nursing
18. Louisiana Association of Nurse Practitioners
19. Medicine Louisiana, Inc.
20. Louisiana Chapter of the American Academy of Pediatrics
21. Louisiana Board of Optometry Examiners

C. Meetings

The workgroup met on August 19, 2011 at the Board of Pharmacy offices in Baton Rouge. Background information on the evolution of electronic prescribing of controlled substances, electronic prior authorizations, and information relating to legislation in several states was discussed. Background information that was used by the workgroup may be found in the appendices.

Subsequently staff drafted the report inviting feedback from the participants which was incorporated in subsequent drafts. The workgroup received permission to extend the submission deadline one month to facilitate participant review. A second meeting of the workgroup was held on January 18, 2012. Comments on the final draft from the participants may also be found in the appendices.

II. Background and Findings

A. Regulatory Framework

1. State laws govern the prescribing and dispensing of prescription drugs by licensed health care professionals as well as the practice of pharmacy.
2. Federal law sets minimum standards for prescribing, transmitting, and dispensing controlled substances.

B. Electronic Prescribing and Electronic Authorization

1. Electronic prescribing is the generation, transmission and filling of a prescription by electronic means.
2. Electronic prior authorization is the process of obtaining pre-approval from a payer for specified medications or quantities of medications, by electronic means.
3. Electronic prescribing is replacing paper prescribing in the United States and elsewhere. There is great interest in electronic prior authorization but development is further behind.
4. Electronic prescribing and electronic prior authorization, when compared to

paper prescribing and paper and telephone prior authorization, has the potential to improve the quality, safety and cost of care.

5. The benefits of electronic prescribing and electronic prior authorization depend on the development of systems that are standardized, user friendly and integrated into related electronic record keeping systems and work flows.
6. Standardization of electronic prescribing and electronic prior authorization is best achieved through the development of national, rather than local, standards or mandates.
7. State initiatives should be limited to removing barriers to implementation and maximizing opportunities for achieving the benefits of electronic prescribing and electronic prior authorization.
8. Advertising should not be permitted in electronic prescribing systems. This prohibition should not preclude the inclusion of coverage information.

III. Recommendations

A. Prohibit advertising in electronic prescribing and electronic prior authorization systems. The prohibition on advertising, however, should not include coverage information. [Purpose 1]

B. Permit standards for electronic prescriptions and electronic prior authorization to evolve nationally without imposition of standards at the state level. [Purposes 2-9]

C. Eliminate barriers to implementation of electronic prescriptions and electronic prior authorization in state law and regulation. [Purposes 2-9]

Appendices

Regular Session, 2011 **ENROLLED**

SENATE RESOLUTION NO. 81

BY SENATOR MILLS

A RESOLUTION

To create the Legislative Workgroup on Electronic Prescribing to study and make recommendations concerning electronic prescribing.

WHEREAS, Louisiana is working to adopt electronic medical records systems; and

WHEREAS, a survey of physicians recently conducted by the American Medical Association found significant concerns among physicians about health insurer prior authorization requirements for both procedures and prescription medications, as well as the timely adjudication of such matters; and

WHEREAS, prior authorization programs have the potential to delay or limit access to needed treatments; and

WHEREAS, emerging electronic medical record systems may increasingly offer physicians the convenience of knowing whether a medication is covered by a health plan, and whether there are utilization management limitations associated with a medication, but health plans continue to require the submission of a prior authorization request via a paper system; and

WHEREAS, physicians often do not know the criteria for approval by a health plan of a requested treatment; and

WHEREAS, the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), provides federal incentives for Medicare and Medicaid providers and hospitals to implement, adopt and upgrade health information technology, including electronic prescribing and electronic health record systems; and

WHEREAS, states are responsible for administering the incentive payments, and have already begun embarking on their own health IT initiatives; and

WHEREAS, the United States Department of Health and Human Services recently released guidance encouraging states to pursue the implementation of health information technology as a key to driving down health care costs; and

SR NO. 81 **ENROLLED**

WHEREAS, the goals of electronic prescribing and health information technology systems are to strengthen the physician patient relationship, improve patient care by allowing physicians to coordinate care across all specialties/fields, facilitate improved quality management of chronic disease thereby reducing health system costs, and allow physicians to monitor medication adherence.

THEREFORE, BE IT RESOLVED that the Senate of the Legislature of Louisiana does hereby establish and create the Legislative Workgroup on Electronic Prescribing to study and make recommendations to the legislature concerning electronic prescribing which at a minimum would accomplish the following:

(1) Seek to limit marketing in electronic health record systems.

(2) Seek to encourage the provision of evidence based information at the point of care for the prescriber and patient.

(3) Standardize prior authorization to maximize administrative simplification and efficiency and adopt a universal prior authorization form to be made available for electronic use.

(4) Provide for a patient's freedom of choice with respect to the selection of a pharmacy.

(5) Provide for user authentication, audit, and physical security.

BE IT FURTHER RESOLVED that the Legislative Workgroup on Electronic Prescribing is hereby established and shall be composed of the following members

(1) One representative appointed by the Louisiana State Board of Pharmacy who will serve as co-chair.

(2) One representative of the Louisiana State Board of Medical Examiners who will serve as co-chair.

(3) One representative of the Department of Health and Hospitals.

(4) One representative of the Department of Insurance.

(5) One representative appointed by the Louisiana State Medical Society.

(6) One representative appointed by the Louisiana Academy of Family Physicians.

(7) One representative appointed by the Louisiana Independent Pharmacies Association.

(8) One representative appointed by the Pharmaceutical Researchers and Manufacturers of America.

(9) One representative appointed by the Louisiana Association of Health Plans.

(10) One representative appointed by the Louisiana Healthcare Quality Forum.

(11) One representative appointed by the Louisiana Hospital Association.

(12) One representative of the Louisiana Workman's Compensation Commission.

(13) One representative of the Louisiana Association of Self Insured Employers.

(14) One representative of eQHealth Solutions.

(15) One representative of the National Association of Chain Drug Stores.

(16) One representative of the Louisiana Orthopedic Association.

(17) One representative of the Louisiana State Board of Nursing.

(18) One representative of the Louisiana Association of Nurse Practitioners

(19) One representative of Medicine Louisiana, Inc.

(20) One representative of the Louisiana Chapter of the American Academy of Pediatrics.

(21) One representative of the Louisiana State Board of Optometry Examiners.

BE IT FURTHER RESOLVED that the workgroup shall study and provide recommendations on the following aspects of electronic prescribing systems:

(1) Best practices to maintain a neutral platform for the secure electronic transmission of health data including, but not limited to medication history, formulary status, and other patient information health professionals typically access when prescribing medication and other interventions.

(2) Best practices to assure attempts to influence, through economic incentives or otherwise, the prescribing decisions of the practitioner at the point of care can be kept to a minimum and focused on patient safety and outcomes that maximize patient and provider freedom of choice.

(3) Best practices to assure messages in electronic prescribing systems are substantially supported by scientific evidence, accurate, up to date, and fact based, including a fair and balanced presentation of risks and benefits, and support for better clinical decision making, such as alerts to adverse events and access to formulary information.

(4) Best practices to establish a process to provide electronic prior authorization request and approval transactions between providers and group purchasers.

BE IT FURTHER RESOLVED that the Louisiana Board of Pharmacy and the Louisiana State Board of Medical Examiners shall coordinate, facilitate and support the functions and duties of the Legislative Workgroup on Electronic Prescribing.

BE IT FURTHER RESOLVED that the Legislative Workgroup on Electronic Prescribing shall submit a report to Senate Committee on Health and Welfare, the Louisiana Board of Pharmacy, and the Louisiana State Board of Medical Examiners on or before January 1, 2012.

BE IT FURTHER RESOLVED that the Louisiana Board of Pharmacy and the Louisiana State Board of Medical Examiners shall coordinate, facilitate, and support the functions and duties of the study group.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the Louisiana Board of Pharmacy, the Louisiana State Board of Medical Examiners, the Louisiana Department of Health and Hospitals, the Louisiana Department of Insurance, the Louisiana State Medical Society, the Louisiana Academy of Family Physicians, the Louisiana Independent Pharmacies Association, Pharmaceutical Researchers and Manufacturers of America, the Louisiana Association of Health Plans, the Louisiana Healthcare Quality Forum, the Louisiana Hospital Association, the Louisiana Workman's Compensation Commission, Louisiana Association of Self Insured Employers, eQHealth Solutions, the National Association of Chain Drug Stores, the Louisiana Orthopedic Association, Louisiana State Board of Nursing, the Louisiana Association of Nurse Practitioners, Medicine Louisiana, Inc., the Louisiana Chapter of the American Academy, and the Louisiana State Board of Optometry Examiners.

PRESIDENT OF THE SENATE

ENROLLED

Regular Session, 2011

HOUSE RESOLUTION NO. 108

BY REPRESENTATIVE LEBAS

A RESOLUTION

To create the Legislative Workgroup on Electronic Prescribing to study and make recommendations concerning electronic prescribing.

WHEREAS, Louisiana is working to adopt electronic medical records systems; and

WHEREAS, a survey of physicians recently conducted by the American Medical Association found significant concerns among physicians about health insurer prior authorization requirements for both procedures and prescription medications, as well as the timely adjudication of such matters; and

WHEREAS, prior authorization programs have the potential to delay or limit access to needed treatments; and

WHEREAS, emerging electronic medical record systems may increasingly offer physicians the convenience of knowing whether a medication is covered by a health plan, and whether there are utilization management limitations associated with a medication, but health plans continue to require the submission of a prior authorization request via a paper system; and

WHEREAS, physicians often do not know the criteria for approval by a health plan of a requested treatment; and

WHEREAS, the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA), provides federal incentives for Medicare and Medicaid providers and hospitals to implement, adopt, and upgrade health information technology, including electronic prescribing and electronic health record systems; and

WHEREAS, states are responsible for administering the incentive payments, and have already begun embarking on their own health IT initiatives; and

HR NO. 108 **ENROLLED**

WHEREAS, the United States Department of Health and Human Services recently released guidance encouraging states to pursue the implementation of health information technology as a key to driving down health care costs; and

WHEREAS, the goals of electronic prescribing and health information technology systems are to strengthen the physician patient relationship, improve patient care by allowing physicians to coordinate care across specialties and fields, facilitate improved quality management of chronic disease and thereby reduce health system costs, and allow physicians to monitor medication adherence.

THEREFORE, BE IT RESOLVED that the House of Representatives of the Legislature of Louisiana does hereby establish and create the Legislative Workgroup on Electronic Prescribing to study and make recommendations to the legislature concerning electronic prescribing which at a minimum would accomplish the following:

(1) Seek to limit marketing in electronic health record systems.

(2) Seek to encourage the provision of evidence-based information at the point of care for the prescriber and patient.

(3) Standardize prior authorization to maximize administrative simplification and efficiency and adopt a universal prior authorization form to be made available for electronic use.

(4) Provide for a patient's freedom of choice with respect to the selection of a pharmacy.

(5) Provide for user authentication, audit, and physical security.

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(1) One representative appointed by the Louisiana State Board of Pharmacy who will serve as co-chair.

(2) One representative of the Louisiana State Board of Medical Examiners who will serve as co-chair.

(3) One representative of the Department of Health and Hospitals.

(4) One representative of the Department of Insurance.

(5) One representative appointed by the Louisiana State Medical Society.

(6) One representative appointed by the Louisiana Academy of Family Physicians.

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(18) One representative of the Louisiana Association of Nurse Practitioners.

(19) One representative of Medicine Louisiana, Inc.

(20) One representative of the Louisiana Chapter of the American Academy of Pediatrics.

(21) One representative of the Louisiana State Board of Optometry Examiners.

BE IT FURTHER RESOLVED that the workgroup shall study and provide recommendations on the following aspects of electronic prescribing systems:

(1) Best practices to maintain a neutral platform for the secure electronic transmission of health data, including but not limited to medication history, formulary status, and other patient information which health professionals typically access when prescribing medication and other interventions.

(2) Best practices to assure attempts to influence, through economic incentives or otherwise, the prescribing decisions of the practitioner at the point of care can be kept to a minimum and focused on patient safety and outcomes that maximize patient and provider freedom of choice.

(3) Best practices to assure messages in electronic prescribing systems are substantially supported by scientific evidence, accurate, up to date, and fact based, including

a fair and balanced presentation of risks and benefits, and support for better clinical decisionmaking, such as alerts to adverse events and access to formulary information.

(4) Best practices to establish a process to provide electronic prior authorization request and approval transactions between providers and group purchasers.

BE IT FURTHER RESOLVED that the Louisiana Board of Pharmacy and the Louisiana State Board of Medical Examiners shall coordinate, facilitate, and support the functions and duties of the Legislative Workgroup on Electronic Prescribing.

BE IT FURTHER RESOLVED that the Legislative Workgroup on Electronic Prescribing shall submit a report to House Committee on Health and Welfare, the Louisiana Board of Pharmacy, and the Louisiana State Board of Medical Examiners on or before January 1, 2012.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the Louisiana Board of Pharmacy, the Louisiana State Board of Medical Examiners, the Louisiana Department of Health and Hospitals, the Louisiana Department of Insurance, the Louisiana State Medical Society, the Louisiana Academy of Family Physicians, the Louisiana Independent Pharmacies Association, Pharmaceutical Researchers and Manufacturers of America, the Louisiana Association of Health Plans, the Louisiana Healthcare Quality Forum, the Louisiana Hospital Association, the Louisiana Worker's Compensation Corporation, Louisiana Association of Self Insured Employers, eQHealth Solutions, the National Association of Chain Drug Stores, the Louisiana Orthopedic Association, Louisiana State Board of Nursing, the Louisiana Association of Nurse Practitioners, Medicine Louisiana, Inc., the Louisiana Chapter of the American Academy of Pediatrics, and the Louisiana State Board of Optometry Examiners.

SPEAKER OF THE HOUSE OF REPRESENTATIVES

Roster of Participants

Members

1	Louisiana Board of Pharmacy	Carl W Aron
2	Louisiana Board of Medical Examiners	Robert L Marier, MD
3	Louisiana Department of Health and Hospitals	Joshua Hardy
4	Louisiana Department of Insurance	Carol Guidry
5	Louisiana State Medical Society	Stephen Hosea, MD
6	Louisiana Academy of Family Physicians	Ragan C LeBlanc
7	Louisiana Independent Pharmacies Association	Marty R McKay
8	Pharmaceutical Researchers & Manufacturers of America	Darrick A LeBeouf
9	Louisiana Association of Health Plans	Milam Ford
10	Louisiana Health Care Quality Forum	Cindy Munn
11	Louisiana Hospital Association	Jennifer McMahon
12	Louisiana Workers' Compensation Corporation	Katharine Rathbun, MD
13	Louisiana Association of Self Insured Employers	Gary Patureau
14	eQHealth Solutions	Trent James, MD
15	National Association of Chain Drug Stores	Mary Staples
16	Louisiana Orthopedic Association	Cindy Bishop
17	Louisiana Board of Nursing	Barbara Morvant, RN
18	Louisiana Association of Nurse Practitioners	Lisa Bayhi, APRN
19	Medicine Louisiana, Inc.	Berkley Durbin
20	Louisiana Chapter, American Academy of Pediatrics	Ashley Politz
21	Louisiana Board of Optometry Examiners	James A Sandefur, OD

Others

Louisiana Board of Pharmacy	Malcolm J Broussard
Louisiana Board of Medical Examiners	J Michael Burdine, MD
	Cecilia Mouton, MD; Phil Bergeron
Louisiana Department of Health and Hospitals	MJ Terrebonne; Christine Peck
Louisiana State Medical Society	Jennifer Marusak; Greg Wadell
Pharmaceutical Researchers & Manufacturers of America	Peter Martinez
Louisiana Association of Health Plans	Gil Dupre
Louisiana Hospital Association	John Matessino
National Association of Chain Drug Stores	Jim Nichols
Louisiana Association of Nurse Practitioners:	Sophia Thomas, APRN
Medicine Louisiana, Inc.	Harold Brandt, MD
Louisiana Senate	Sen. Fred Mills
Louisiana House of Representatives	Rep. H. Bernard LeBas

surescripts®

THE NATIONAL PROGRESS REPORT

ON E-PRESCRIBING AND INTEROPERABLE HEALTHCARE

YEAR 2010

surescripts®

neutrality

transparency

physician and patient choice

open standards

collaboration

privacy

Appendix C

THE EVOLUTION OF E-PRESCRIBING

2011

2010

- 190,000—or 36%—of office-based physicians e-prescribe.
- Surescripts announces network expansion to allow clinicians to exchange all types of clinical messages with their peers.
- The U.S. Drug Enforcement Administration allows the option of issuing prescriptions for controlled medications electronically.
- Patient Protection and Affordable Care Act passes.

2009

- American Recovery and Reinvestment Act provides $19 billion toward adoption of health information technology.
- CMS releases proposed regulations defining meaningful use of EMRs. E-prescribing is a key component.
- Medicare launches MIPPA e-prescribing incentive program.
- Rhode Island announces 100 percent of its pharmacies are enabled for e-prescribing.
- SureScripts-RxHub is relaunched as Surescripts.

2008

- CMS issues Medicare Part D e-prescribing incentive regulations.
- DEA proposes rule to allow e-prescribing for controlled substances.
- Medicare Improvements for Patients and Providers Act (MIPPA) passes; includes e-prescribing incentives.
- RxHub and SureScripts merge to form SureScripts-RxHub.

2007

- Center for Improving Medication Management launched.
- E-Prescribing becomes legal in all 50 states and D.C.
- National E-Prescribing Safety Initiative launched.
- SureScripts, RxHub, Informed Decisions and the AMA launch ICERx.org to assist victims of natural disasters.

2006

- CMS pilot-tests proposed Medicare Part D e-prescribing standards.
- First annual Safe-Rx Awards recognize top e-prescribing states.
- Institute of Medicine releases pivotal "Preventing Medication Errors" report.

2005

- First proposed "foundation standards" released for Medicare Part D e-prescribing.
- HHS issues Stark exemptions and fraud and abuse safe harbors.
- SureScripts and RxHub help launch www.katrinahealth.org to support victims of Hurricane Katrina.

2004

- Approximately 2,500—or 0.4%—of office-based prescribers use e-prescribing.
- Office of the National Coordinator for Health Information Technology (ONC) is established.
- SureScripts launches e-prescribing community adoption programs.

2003

- Institute of Medicine endorses National Health Information Infrastructure.
- Medicare Modernization Act provides incentives for e-prescribing adoption.
- SureScripts begins network operations.

2002

- RxHub begins network operations.

2001

- RxHub founded.
- SureScripts founded.

INTRODUCTION

A LETTER FROM THE PRESIDENT AND CEO

I am very pleased to introduce *The National Progress Report on E-Prescribing and Interoperable Healthcare for 2010.* The fourth edition of this annual report documents the status of electronic prescribing's adoption and use throughout the U.S. and features a broader analysis of the nation's drive towards more interoperable healthcare.

With over 34 percent of the nation's prescribers actively managing prescriptions electronically and 25 percent of prescriptions transmitted by this method at the end of 2010, e-prescribing is now well on its way to becoming mainstream practice. Replacing phone-, fax- and paper-based prescribing with secure electronic exchange is improving medication management, increasing patient convenience and reducing costs for all healthcare participants. What's more, the factors behind e-prescribing's success serve as a model for broader adoption and use of health IT.

The unprecedented collaboration between the public and private sectors—Whether working together on standards or on the appropriate mix of incentives for providers, the growth of e-prescribing has proven the critical importance and effectiveness of collaboration between federal and state governments and the entire healthcare industry.

The many tangible benefits for all e-prescribing participants—Benefits include fewer medical errors due to poor handwriting; greater awareness of potential adverse drug interactions; more effective communication of a patient's insurance coverage and generic alternatives; increased adherence; more accurate, efficient and lower-cost means for physicians, pharmacies and payers to communicate and process prescriptions; and a more convenient means for patients to obtain the prescription drugs they need.

Surescripts' commitment to collaborating with all healthcare participants to realize a neutral nationwide e-prescribing network—In addition to neutrality and collaboration, Surescripts' long-standing principles of transparency, open standards, protection of physician choice of therapy and patient choice of pharmacy, and privacy protection have created an ecosystem that enables the rapid growth of e-prescribing.

The vision and support of the nation's community pharmacies and leading PBMs—Ten years ago, leaders from these organizations saw the opportunity and took action together to dramatically improve one of the largest segments of the nation's healthcare system.

And now Surescripts is pleased to extend this model to allow providers to exchange clinical information with their peers. In doing so, we are responding to a clear need in the market for a nationwide network for clinical interoperability, one that supports HITECH Meaningful Use requirements and serves emerging models of collaborative care. We are committed to applying the same principles and lessons learned from e-prescribing to further inform and improve health care outcomes, patient safety, and the overall doctor-patient relationship.

I encourage you to explore our 2010 report to learn more about how e-prescribing and interoperable healthcare are growing and driving the digital transformation of the nation's healthcare system.

Regards,

Harry Totonis
President and CEO, Surescripts

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CONTENTS

INTRODUCTION

The need for the secure and timely electronic exchange of clinical health information has been identified as fundamental for supporting ongoing improvements in the quality and efficiency of healthcare.

The combination of an aging population and higher demands for healthcare through recent reform efforts is accelerating the demand and adoption of health-related technology. Government incentive programs consider the use of such technology to be critical toward promoting a more efficient and more collaborative environment for patient care.

Measuring the adoption and use of health information technology will be essential to determine if such technology is living up to its promise. As the most established form of electronic clinical message exchange, electronic prescribing (e-prescribing) can serve as a valuable bellwether for assessing the overall use of health-related technology. As evidenced through e-prescribing's high rates of growth, the electronic exchange of healthcare information is on a path to becoming mainstream.

As the organization that manages the nation's e-prescription network, Surescripts has been in an ideal position to observe and report on the growth of e-prescribing through its annual *National Progress Report on E-Prescribing*. This year's report tracks the adoption and use of e-prescribing between 2008 and 2010.

For 2010, the *Report* offers analysis of statistical trends and underlying factors that extend beyond e-prescribing. Future editions of the *Report* will feature qualitative and quantitative analysis on a broader set of factors driving the overall interoperability of the nation's healthcare system.

EXECUTIVE SUMMARY

E-Prescribing Adoption and Use

Significant growth was seen between 2008 and 2010 in the adoption and use of the three critical steps that enable the e-prescribing process: prescription benefit, medication history and prescription routing.

Part 1: Electronic Prescribing Use

- **Prescription Benefit:** Electronic responses to requests for prescription benefit information grew 125% from 188 million in 2009 to 423 million in 2010.
- **Medication History:** Prescription histories delivered to prescribers grew 184% from 81 million in 2009 to 230 million in 2010.
- **Prescription Routing:** Prescriptions routed electronically grew 72% from 191 million in 2009 to 326 million in 2010.
- **EHR vs. Standalone E-Prescribing Software:** About 79 percent of prescribers used EMRs in 2010, up from 70 percent in 2009.

Part 2: Electronic Prescribing Adoption

- **Prescribers:** The number of prescribers routing prescriptions electronically grew from 156,000 at the end of 2009 to 234,000 by the end of 2010—representing about 34 percent of all office-based prescribers.
- **Payers:** At the end of 2010, Surescripts could provide access to prescription benefit and history information for more than 66 percent of patients in the U.S.
- **Community and Mail Order Pharmacies:** At the end of 2010, approximately 91 percent of community pharmacies in the U.S. were connected for prescription routing and six of the largest mail order pharmacies were able to receive prescriptions electronically.

Part 3:
Industry Drivers

The federal government is playing a significant role in influencing the growth of interoperable health technologies.

Drivers of Interoperable Healthcare in 2010

- **HITECH:** Incentive programs offered through the Health Information Technology for Economic and Clinical Health Act.
- **MIPPA:** Incentive programs offered through the Medicare Improvements for Patients and Providers Act.

Future Drivers of Interoperable Healthcare Growth

- **PPACA:** Reform efforts under the Patient Protection and Affordable Care Act.
- **EPCS:** DEA regulatory changes that give prescribers the option of issuing prescriptions for controlled substances electronically.

Recommendations

To support the continued growth of interoperable healthcare—including e-prescribing—Surescripts recommends extending the collaboration between government and industry in order to:

- **Drive utilization:** Continue to develop programs that focus on driving the utilization of e-prescribing and interoperable health technologies.
- **Bridge adoption gaps:** Address gaps in e-prescribing and EHR adoption by solo practitioners, by independently owned pharmacies and by state Medicaid programs.
- **Promote clinical collaboration:** Support emerging collaborative models of care.

INTRODUCTION

PROFILES IN INTEROPERABLE HEALTHCARE:

CREATING CONNECTIONS THAT LAST—A Q&A WITH SURESCRIPTS' BOARD OF DIRECTORS

Surescripts was founded by the nation's retail pharmacies and the largest pharmacy benefit managers to transform the delivery, safety and efficiency of healthcare. Though long-time competitors, the benefits to all healthcare consumers compelled pharmacies and PBMs to take action together—despite their differences. By creating a neutral network based on industry standards, the Surescripts network has grown to become the nation's largest health information network.

The following interview with the Surescripts board of directors highlights how this was accomplished and how the Surescripts network creates a unique opportunity for all parts of the nation's healthcare system to connect, collaborate and transform healthcare.

Surescripts' Board of Directors
John Driscoll (Co-Chairman)—Medco Health Solutions
Donald C. Huonker (Co-Chairman)—Walgreens
Steve B. Miller, M.D.—Express Scripts
Ralph Petri—Kerr Drug
Jeffery T. Smith—CVS Caremark
Doug Hoey, R.Ph.—National Community Pharmacists Association

It's no secret that your organizations have been seen as competitors by the industry. What ultimately made you decide to work together when it came to e-prescribing and Surescripts?

John Driscoll: Much of our decision to work together stemmed from a shared belief in the benefits and opportunities that exist with e-prescribing. E-prescribing is inclusive of every party interested in high-quality, accurate and affordable prescriptions.

Don Huonker: Surescripts enables all "boats to rise"—independent of business model and whether or not we may be competitors. In the end, working together lets us improve health outcomes for our patients and enables lower costs for the healthcare system.

What role does e-prescribing play and what value does it bring to the nation's efforts to reform healthcare?

John Driscoll: With e-prescribing, we have a working parable of success. It enhances the entire healthcare system by bringing to bear 21st-century technological standards for mobility and quick and secure access to information. Moreover, e-prescribing improves outcomes for all parties and reduces costs.

Don Huonker: E-prescribing enables improved health outcomes while helping to lower costs—the sweet spot of health reform. E-prescribing improves the safety and quality of the prescribing process while reducing costs by increasing efficiencies for all stakeholders in the value chain. The neutrality and transparency of Surescripts help enable this collaborative solution.

"E-PRESCRIBING IS INCLUSIVE OF EVERY PARTY INTERESTED IN HIGH-QUALITY, ACCURATE AND AFFORDABLE PRESCRIPTIONS."

Are you surprised by the significant growth in e-prescribing, or is it in line with what you thought was possible when Surescripts began?

Steve Miller: The growth of e-prescribing has surprised me in several regards. In the first place, adoption and growth have been much slower than any of us anticipated 15 years ago. For what appears to be a compelling case (safer, more affordable and more convenient), the initial uptake was much slower than originally anticipated. However, the growth in the last two years has been astonishing. We have reached the proverbial tipping point.

What do you think are the most significant benefits that e-prescribing has brought to the market?

Ralph Petri: The most significant benefit e-prescribing has brought to the market is a high-quality electronic network that allows providers to communicate in a very secure and efficient manner. Surescripts has created a platform that will enable healthcare providers to use the network for many more healthcare transactions, which will ultimately lead to much improved health outcomes at a significant savings.

Many point to Surescripts' neutrality and collaboration as two of its key attributes. What do neutrality and collaboration mean to your organizations, and why are they important to a network like Surescripts?

Steve Miller: Surescripts has been successful because it is both collaborative and neutral. Prior to the merger of RxHub and Surescripts, you had two distinct entities competing in the same space. By collaborating and merging, the combined company became greater than the sum of the two parts. It was truly synergistic. Continued growth has occurred because the diverse ownership has required ongoing collaboration and neutrality.

"NEUTRALITY AND COLLABORATION ARE ESSENTIAL FOR SURESCRIPTS TO SUCCEED."

Ralph Petri: Neutrality and collaboration are essential for Surescripts to succeed. Competing providers must have confidence that the network is being used to advance improved patient outcomes and not provide any specific advantage to individual providers or segments of the market.

Some skepticism appears to exist around e-prescribing for some independents. How has e-prescribing benefited independents? What still needs to be done to get everyone connected?

Doug Hoey: Years ago, when many pharmacies first signed up, there was not a critical mass of e-prescriptions coming in from physicians. However, now that we are seeing 20 percent of prescriptions coming through as e-prescriptions, the need is much clearer.

From a benefit standpoint, we are starting to see increased efficiency and safety. Increased efficiency allows pharmacists more time to spend with patients—i.e., more time to provide clinical services that they often don't have time for.

The physician incentives have clearly worked to attract more physicians to e-prescribing. This, in turn, has helped spur demand among independent pharmacies. The vast majority of independent pharmacies are now e-prescribing and I believe we are at the last mile.

How important are the principles of neutrality and collaboration when it comes to facilitating the broader exchange of health information (e.g., labs, referrals, summaries)?

Jeff Smith: Healthcare is undergoing a fundamental shift. Managing costs is not enough—all stakeholders must drive outcomes. This, in turn, is driving healthcare toward a more integrated, more collaborative model of care in which providers need access to the right information at the right time. Without neutrality, nobody can support this new business model.

Doug Hoey: Those are the cornerstones of Surescripts and they are absolutely essential to facilitating broader health information exchange. It is important to keep in mind that the Surescripts network is voluntary. Organizations choose to collaborate on the network. If an organization ever felt it was being disadvantaged, it would no longer use the network. If organizations stop using the network, then there is no collaboration. Without collaboration, you lose the integration of healthcare that leads to lower costs and better patient outcomes.

E-prescribing has grown more than sixfold in the last two years. What lessons can the nation apply to achieve similar rates of growth in clinical message exchange?

Jeff Smith: The first lesson is that everyone must benefit from the system. With e-prescribing, physicians, pharmacies, payers and patients all benefit from improved safety and efficiency.

"BY ENABLING COLLABORATION BETWEEN HEALTHCARE PROVIDERS, WE ARE OPTIMIZING THE SYSTEM..."

The second lesson is that e-prescribing has proven that collaboration works. Take standards as an example. Pharmacies, PBMs and prescriber technology vendors demonstrated—through their work with NCPDP—how to develop standards in an inclusive way that would be acceptable to all. Driving ease of use is another example: e-prescribing really started to take off when it became easier for prescribers to implement. Improved ease of use was enabled by stakeholders collaborating on certification and otherwise working together to improve the prescriber experience.

Surescripts and MinuteClinic have already taken these lessons and successfully applied them to clinical message exchange. As one of the earliest implementations of the CCR standard, MinuteClinic nurse practitioners are able to exchange clinical messages with their patients' physicians. By enabling collaboration between healthcare providers, we are optimizing the system and creating better outcomes for patients.

REVIEW: E-PRESCRIBING UTILIZATION AND ADOPTION GROWTH

Electronic prescribing, or 'e-prescribing,' supports a shift to a paperless and more informed way for prescribers, payers and pharmacists to make clinical decisions and improve work flows related to medication management.[1]

Significant growth was seen between 2008 and 2010 in the adoption and use of the three critical services that enable the e-prescribing process: prescription benefit, medication history and prescription routing.

PART 1: ELECTRONIC PRESCRIBING USE

PRESCRIPTION BENEFIT

Surescripts works with the nation's payers and PBMs to offer prescribers access to their patients' prescription benefit—formulary and eligibility—information in real time during a patient encounter.

Electronically accessing a patient's prescription benefit information allows prescribers to choose medications that are on formulary and are covered by a patient's drug benefit.

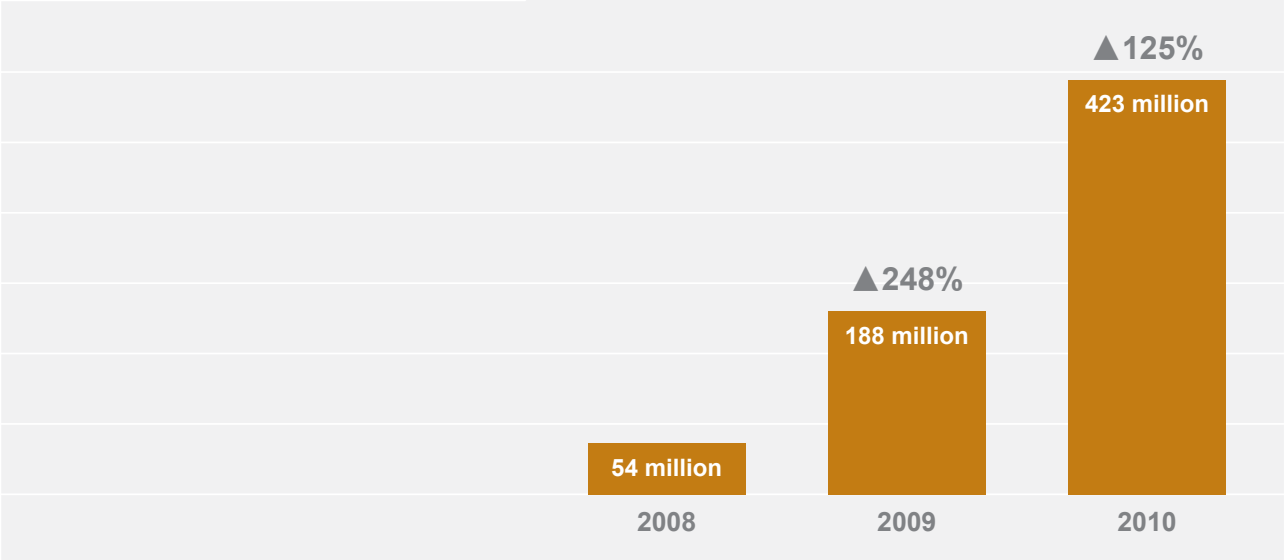
Prescribers access prescription benefit information using software provided by a vendor that is certified by Surescripts for this service.[2]

1 IN 3 PATIENT VISITS NOW INCLUDES THE OPPORTUNITY TO LOWER PRESCRIPTION COSTS

KEY STATISTICS

- Electronic responses to requests for prescription benefit information grew 125 percent in 2010.
- Approximately 36 percent of patient visits involved one of these responses in 2010, up from 19 percent in 2009.[3]
- On average, the response rate to prescription benefit requests (the rate at which information for the patient can be returned to the prescriber) was approximately 69% in 2010, up from 62% in 2009.

Prescription Benefit Responses



Contributing Factors	2008	2009	2010
Active Prescribers (pg. 15)	74,000	156,000	234,000
Number of E-Prescribing Applications Certified for this Service (pg. 14)	43	78	137

Page 8 Footnote:
1 To view a demonstration of how e-prescribing works, please visit http://www.surescripts.com/about-e-prescribing/how-e-prescribing-works.aspx.
Page 9 Footnotes:
2 For more information about Surescripts certification, go to http://surescripts.com/connect-to-surescripts/certification-overview.aspx.
3 According to the August 2009 National Ambulatory Medical Care Summary, an estimated 956 million visits were made to office-based physicians in 2008 (data released 2010), an average of about 309 visits for every 100 persons—using 2010 U.S. population figure of approximately 309 million.

PART 1: ELECTRONIC PRESCRIBING USE

MEDICATION HISTORY

MEDICATION HISTORY AVAILABLE FOR MORE THAN TWICE AS MANY OFFICE VISITS IN 2010

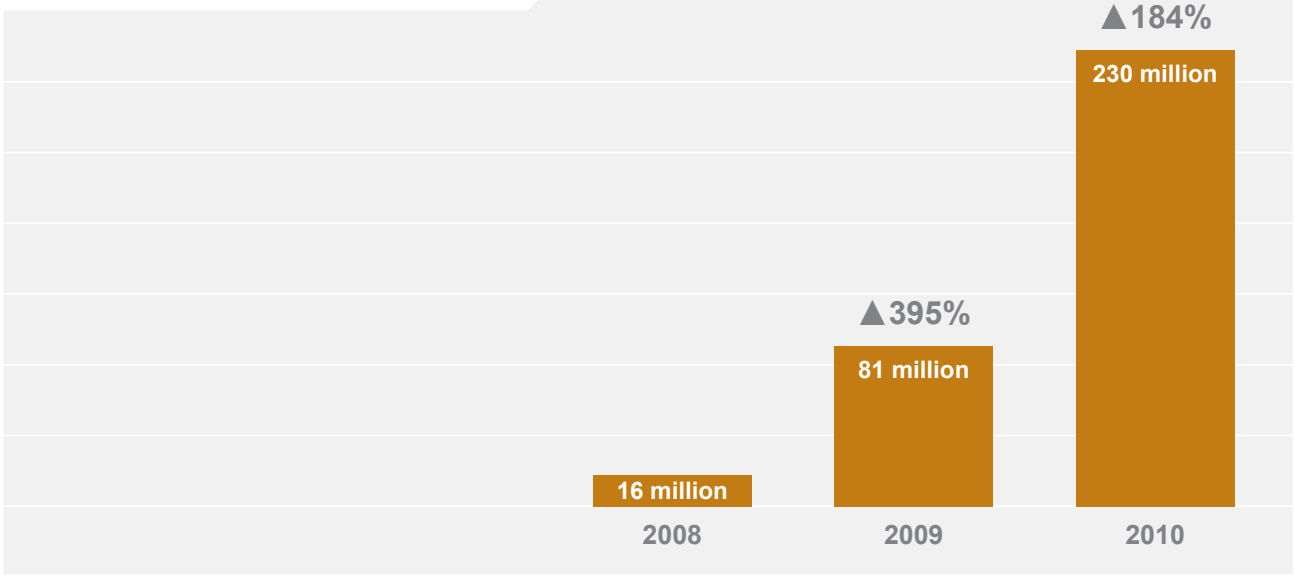
With a patient's consent,[4] medication history allows a prescriber to review a more complete record of patient medication by electronically requesting and receiving history information from payers and community pharmacies.

Surescripts works with payers and community pharmacies to make this information available to prescribers nationwide. Prescribers access medication history information through software provided by a vendor that is certified by Surescripts for this service.

KEY STATISTICS

- The number of medication histories delivered to prescribers electronically grew 184 percent.
- Approximately 24 percent of patient visits involved an electronically delivered medication history in 2010, up from 9 percent in 2009.
- In addition, medication history was electronically accessed by clinicians working in acute-care environments to support transitions in care.
- In 2010, over 14.6 million medication histories were delivered to clinicians in this environment.

Medication Histories Delivered



Contributing Factors	2008	2009	2010
Active Prescribers (pg. 15)	74,000	156,000	234,000
Number of E-Prescribing Applications Certified for this Service (pg. 14)	42	76	133

4 For information on how Surescripts handles personal health information, please review our Privacy Policy on our Web site at: www.surescripts.com/about-us/commitment-to-privacy.aspx.

PROFILES IN INTEROPERABLE HEALTHCARE

MEDICATION HISTORY IN THE ACUTE SETTING

Dr. Tom McGill, Vice President, Quality and Safety
Butler Health System, Butler, PA

"You can't practice good medicine if you don't have an accurate, up-to-date medication list for the patient. This service has added significant value for us in terms of vastly expanding the physician's knowledge base."

Introduction

As aggregated records of patient medication history can now be delivered to acute-care settings, hospitals and other institutions are now finding new ways to streamline the medication reconciliation process.

Description

With more than 40,000 patients per year coming into their ER, Butler Health System was looking for solutions to help streamline the medication-reconciliation process. Medication reconciliation—in the absence of networked health technology—involves generating an active medication list for each incoming patient by using a combination of an interview process and phone- or fax-based follow-ups. Completeness and accuracy in the process are paramount, but the time needed to achieve it can be significant. While a Joint Commission standard, real-world performance of medication reconciliation can have significant flaws.

As a forward-looking institution, Butler piloted electronically sourced medication history as part of a larger program to build efficiencies, adopt patient-centered best practices and achieve higher standards of care through the implementation of health technology. This pilot provided an opportunity for Butler to assess the return on investment of this electronic service by comparing the use of technology against standard practice.

Study Design

In a randomized sample of 160 ER visits, Butler compared 71 visits that used electronically accessed patient medication history—accessed through the hospital's Health Monitoring Systems MediCenter application, with a connection to the Surescripts network—with 89 visits that used the standard medication reconciliation process.

Key measurement factors included the number of medications reported, the time needed to acquire a thorough medication history and the extent to which clinically significant medications were discovered.

Results

Through its analysis, Butler determined that use of electronically sourced medication history information achieved an average delivery of approximately 95 percent of current patient medications versus just 70 percent when relying on a patient interview alone. The pilot study also demonstrated that it would take an average of 19 additional minutes of staff time to achieve the 95 percent threshold using standard phone- and fax-based follow-ups.

In addition, when the study control group was reexamined using the acute-care medication history service, a number of clinically significant medications were discovered—including cardiac drugs and antibiotics—that had not been discovered using the interview-based process alone.

Next Steps

Having demonstrated the clinical utility and cost-effectiveness of electronically delivered patient medication history, Butler Health System now uses this service as part of its standard patient intake process within the ER. Future plans include expansion of the service hospital-wide.

PART 1: ELECTRONIC PRESCRIBING USE

1 IN 4 PRESCRIPTIONS IS NOW AN E-PRESCRIPTION

PRESCRIPTION ROUTING

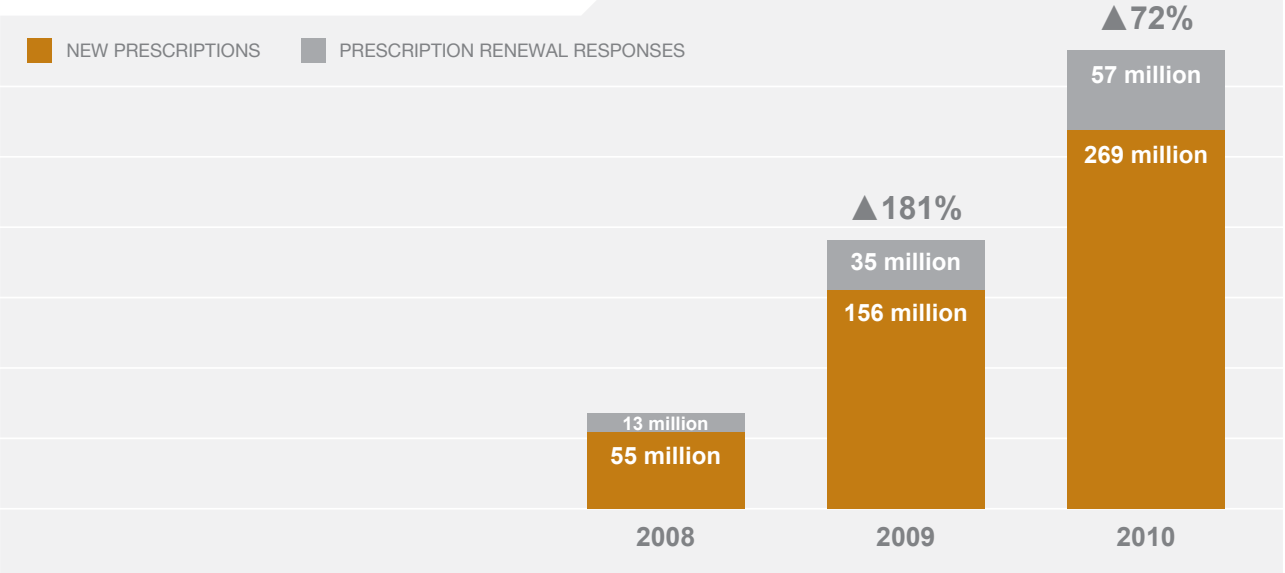
Prescription routing allows new prescriptions to be sent electronically to the computer system at the pharmacy of the patient's choice, as opposed to sending it by fax, calling it in or writing it on paper. Renewal authorization requests can be sent electronically from a pharmacy's computer to a practice's e-prescribing software, where they can be reviewed and responded to.

Prescribers exchange prescription information with pharmacies electronically and bi-directionally using software provided by a vendor that is certified by Surescripts for this service.

KEY STATISTICS

- At the end of 2010, approximately one in four prescriptions was delivered electronically, up from one in 18 prescriptions at the end of 2008.
- About 20 percent of eligible prescriptions were sent electronically in 2010 versus 12 percent in 2009.[5]
- By December 2010, approximately 25 percent of eligible prescriptions were being sent electronically.[6]
- Over 326 million prescriptions were routed electronically in 2010 versus 190 million in 2009—a 72 percent increase.[7]
- Of this, over 8 million electronic prescriptions were routed to mail order pharmacies.

Prescription Routing Transactions



Contributing Factors				
	Active Prescribers (pg. 15)	74,000	156,000	234,000
	Number of E-Prescribing Applications Certified for this Service (pg. 14)	80	134	196
	Connected Community Pharmacies (pg. 19)	76%	85%	91%

PROFILES IN INTEROPERABLE HEALTHCARE

QUALITY: THE KEY TO MORE CONFIDENT, FREQUENT AND MEANINGFUL USE

David Yakimischak, Chief Quality Officer
Surescripts

"We believe that quality must be actively managed and not left to chance."

Through its industry-wide quality program, Surescripts is committed to improving the end-to-end quality of e-prescribing—from the time a prescription is first considered by the prescriber to the time the medication is dispensed and at all points in between. Our efforts to measure, analyze and continually improve quality help us to minimize potential issues while helping to more fully realize the benefits of e-prescribing. We do this in two ways: first, through the management of our own operations, and second, through our end-to-end work with participants on the Surescripts network. This proactive approach requires a combination of skills from pharmacists, clinicians, technologists and Six Sigma Black Belt experts.

While the focus to date has been on e-prescribing, the Surescripts quality management program is being extended to improve other forms of health information exchange. Moving health information electronically is not enough—it must be accurately and reliably communicated. We believe that quality must be actively managed and not left to chance.

Driving Quality Improvements in 2010

In 2010, we took significant steps toward achieving 100 percent reliability of the end-to-end e-prescribing process:

- By conducting clinical quality reviews on millions of electronic prescription messages, Surescripts has been able to measure and analyze the safety, accuracy and completeness of the electronic prescriptions that have flowed through the network.[8] This has enabled Surescripts to publish industry guidelines that define what an electronic prescription should or should not contain in order to convey to the pharmacist and the patient the clinician's therapeutic intent in an accurate, understandable, complete, unambiguous and efficient manner. These guidelines are available at http://www.surescripts.com/eprescribingquality/page/guidelines.aspx.
- Surescripts created quality measurement scorecards for vendors, practices and pharmacies. We shared these scorecards with our network participants and sought their commitment to enhancing their operations as part of the end-to-end focus on quality improvements.
- Surescripts completed the ISO quality standards 17025 and 65 required by the Office of the National Coordinator for Health Information Technology to become an ONC-authorized certification and testing body for e-prescribing in support of the HITECH meaningful use requirements. These independent quality standards confirm that Surescripts is following the highest standards for quality processes.

Quality's Broader Role in Interoperable Healthcare

In 2011, Surescripts will conduct more in-depth measurement and analysis of e-prescribing quality while broadening its perspective to include all types of health information.

Within e-prescribing, Surescripts will go beyond conformance with guidelines to measure how often prescriptions require pharmacy intervention. An intervention is typically defined as a phone call made from the pharmacy back to the prescriber to clarify or confirm the prescriber's intent. Such measurement and analysis will afford the industry a deeper understanding of how much more efficient e-prescriptions are compared to paper prescriptions and what opportunities exist to continually improve that efficiency.

Surescripts will also look to develop new methods for measuring and analyzing the quality of prescription benefit and medication history messages, along with other types of clinical messages. As part of this effort, we will work with physicians, pharmacies, PBMs, payers and the technology vendors that serve all these network participants to gain a more detailed understanding of how quality improvements in work flow, safety and efficiency not only can reduce the risk of potential issues but also provide more value for these participants and the patients they serve. By looking to improve all aspects of quality, Surescripts aims to drive more confident, frequent and meaningful use of health information.

For more information and to get more involved, visit www.surescripts.com/about-us/quality-program.aspx.

Page 12 Footnotes:

5 This calculation is based on the 326 million new prescriptions and renewal responses electronically transmitted in 2010 and the 1.66 billion new prescriptions and renewals eligible for electronic routing in 2010 in the U.S., according to NACDS. (Note: These 1.66 billion prescriptions do not include controlled substances, as Surescripts did not observe any instance of a controlled substance being delivered electronically to pharmacies in a manner compliant with DEA regulations. This figure also excludes preauthorized refills on existing prescriptions, as they do not require communication between a physician and a pharmacist.)

6 Note: The potential addition of prescriptions for controlled substances to the total number of prescriptions that are eligible for electronic routing in 2011 will affect the overall calculations for the percentage of prescriptions that are delivered electronically for the 2011 calendar year. It is estimated that 19 percent of total prescriptions written are for controlled substances, not counting preauthorized refills.

7 Requests for prescription renewals are not represented in this section, as prescription renewal requests do not lead directly to the issuing of prescription orders.

Page 13 Footnote:

8 When conducting clinical quality reviews of prescriptions, no personal health information is accessed.

PART 1: ELECTRONIC PRESCRIBING USE

EHRs OUTNUMBER STANDALONE E-PRESCRIBING APPLICATIONS BY 4 TO 1

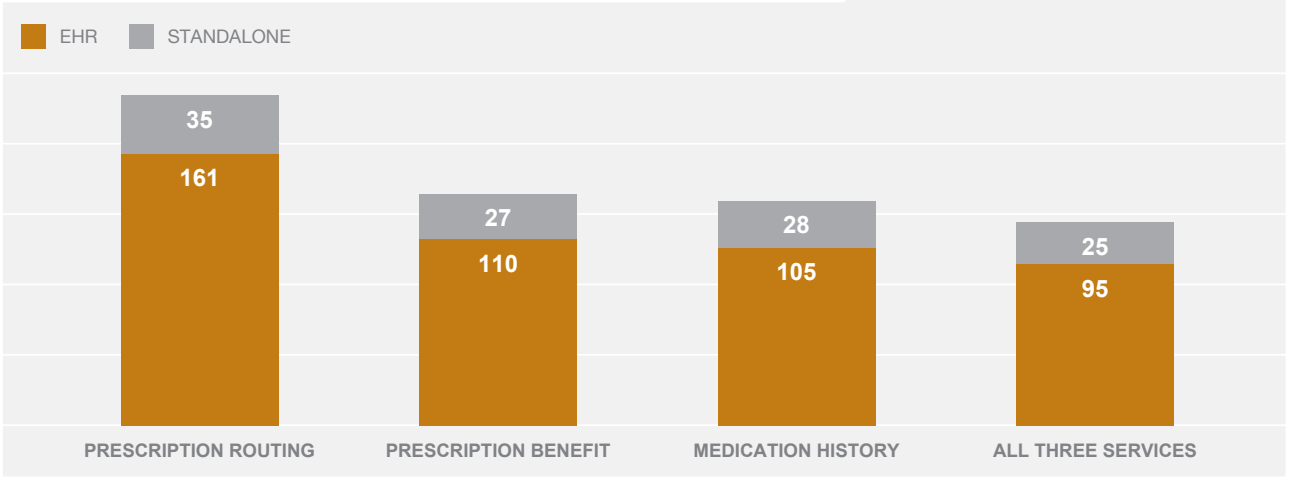
EHR VS. STANDALONE E-PRESCRIBING SOFTWARE

Prescribers e-prescribe using either electronic health record (EHR) software or standalone e-prescribing software. Standalone e-prescribing software performs only the e-prescribing function. By comparison, e-prescribing is integrated as a component within EHR software as one of many functions such as documentation and charge capture.

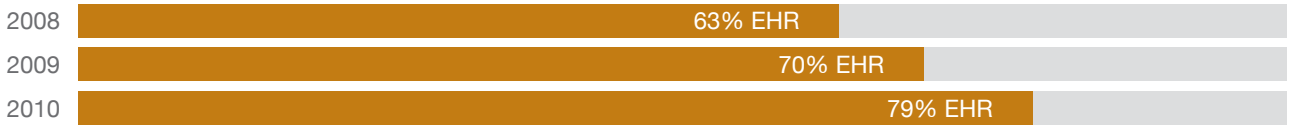
KEY STATISTICS

- About 91 percent of prescribers who used EHRs in 2010 to e-prescribe used one that was deployed for all three e-prescribing services, versus 78 percent in 2009.
- 83 percent of deployed e-prescribing software applications are included within EHRs and 17 percent are standalone.
- 53 percent of certified and deployed EHR software was deployed for all three ambulatory e-prescribing services at the end of 2010—Benefit, Routing, History—compared with 68 percent of standalone software.[9]
- Some standalone e-prescribing software vendors license use of their products to companies that provide EHRs. At the end of 2010, 148 EHRs used imbedded standalone e-prescribing software that was certified for connectivity to the Surescripts network.

Vendor Software Certified and Deployed for E-Prescribing



Percentage of Active Prescribers Using EHR vs. Standalone E-Prescribing Software



PART 2: ELECTRONIC PRESCRIBING ADOPTION

PRESCRIBERS

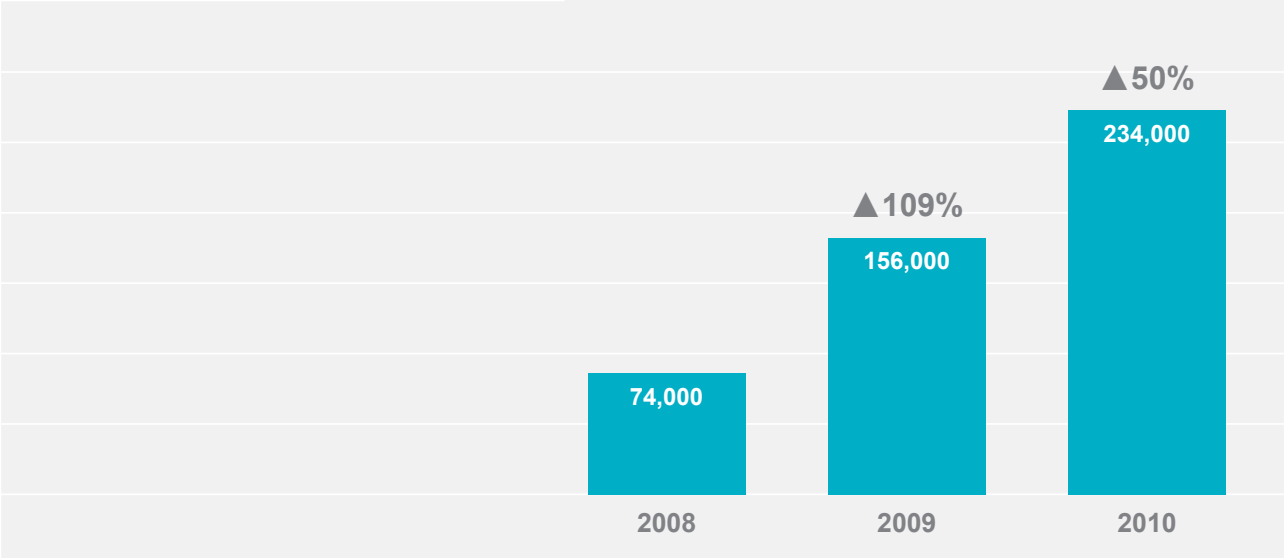
Prescribers using electronic prescribing in the United States include physicians, nurse practitioners and physician assistants. Prescribers use either stand-alone e-prescribing software or an electronic health record (EHR) to e-prescribe. All prescribers described in this section of the *Report* used Prescription Routing services. A portion of these prescribers also used Prescription Benefit and Medication History services.

KEY STATISTICS

- Approximately 234,000 prescribers routed prescriptions electronically by the end of 2010, up from 156,000 at the end of 2009. This represents about 34 percent of all office-based prescribers.[10]
- Of this 234,000, approximately 81 percent were doctors.
- Surescripts estimates that approximately 36 percent of office-based physicians are e-prescribing nationwide.

36% OF OFFICE-BASED DOCTORS USE E-PRESCRIBING

Prescribers Routing Prescriptions



Associated Factors				
	EMR Users (pg. 14)	63%	70%	79%

Page 14 Footnote:

9 Certification for all three e-prescribing services is comprehensive of certification for Prescription Benefit, Medication History and Prescription Routing services. Routing services include connectivity to retail and mail order pharmacy and the ability to manage prescription renewals electronically.

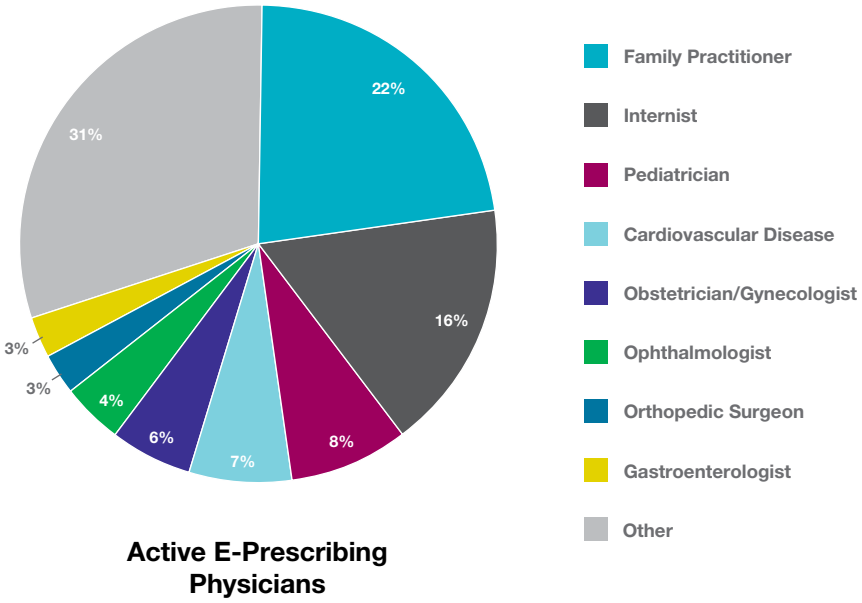
Page 15 Footnote:

10 Based on total count of 679,000 office-based prescribers, per SK&A data. Surescripts counts of active e-prescribers represent those that have used ambulatory prescription routing services within the last 30 days of 2010. A small proportion of these prescribers have been registered by hospitals and other organizations that do both ambulatory and acute care.

PART 2: ELECTRONIC PRESCRIBING ADOPTION

E-PRESCRIBING PHYSICIANS BY SPECIALTY

Surescripts estimates that physicians e-prescribing through the Surescripts network are representative of the following specialties.[11]



Active E-Prescribing Physicians

CARDIOLOGISTS, FAMILY PRACTITIONERS LEAD E-PRESCRIBING ADOPTION

Percentage of Specialists Actively E-Prescribing

Specialty	% E-Prescribing
Cardiovascular Disease	49%
Family Physician	47%
Internist	45%
Ophthalmologist	40%
Gastroenterologist	38%
Pediatrician	36%
Obstetrician/Gynecologist	34%
Orthopedic Surgeon	24%
Other[12]	19%

11 Estimate based on sample analysis of 158,000 physicians (or 80% of all active e-prescribing physicians) over the Surescripts network as of December 2010.
12 "Other" includes specialists such as urologists, neurologists and oncologists.

PROFILES IN INTEROPERABLE HEALTHCARE

HEALTH INFORMATION TECHNOLOGY AND THE FAMILY PRACTITIONER

A conversation with Dr. Steven Waldren, Director, Center for Health-IT
American Academy of Family Physicians (AAFP)

"Accountable care models and medical homes will only work effectively if the communication between these parties can be conducted in a seamless, interoperable manner."

The AAFP has long maintained a focus on influencing the adoption and use of health information technology. Here, Dr. Steven Waldren, director of AAFP's Center for Health Information Technology, shares his perspective on how HIT is shaping the process of clinical care.

Why has the AAFP placed such a focus on health information technology (HIT)?
I believe our focus is a natural extension from the business of being a family practitioner. We find that family doctors are often entrepreneurial, innovative and engaged in the business of medicine. The nature of our membership has allowed us to develop our role as advocates for HIT to the extent that we have.

What do you see as the biggest technology challenge facing the family practitioner right now?
Family doctors are transitioning between established models of medicine and evolving models that are placing increasing focus on collaboration and quality. Health information technology plays an important role in supporting this shift.

We know that our members have been strong adopters of health technologies, with about 60 percent reporting use of electronic health record systems. But these implementations may not ready these practices for future needs. Implementations have typically been done with an eye towards automating documentation, securing remote access and supporting processes necessary to secure reimbursement with current payer-driven models.

Now—with emerging models of accountable care and medical homes, we are seeing a significant shift to more quality-driven care. In this respect we are finding that a minority of our membership—only about 20–30 percent—have implemented the tools to be ready for this change. Examples of what's needed include population management tools, quality-based reporting and so on.

How else is the shift toward accountable care driving the need for health information technology?
Well—you need to look at all participants in a patient's care and their relationships. Today patients see their family practitioner and any number of specialists. Nurses, physician assistants and pharmacists are also involved in this care. Using today's models of communication, the relationships between all these parties can be fragmented. Accountable care models and medical homes will work effectively only if the communication between these parties can be conducted in a seamless, interoperable manner.

And how are practitioners reacting to government efforts to boost use of HIT?
The incentive programs have given HIT a real boost, that's for sure. But recognize that doctors are looking for ways of using their systems to both care for their patients and ensure that they are making the proper documentation to get reimbursed under these programs. I consistently hear from doctors during our AAFP forums that their systems do not always support the type of information capture and support necessary.

For instance, they are required to review history, capture their information to document the care that was delivered and then capture information to support population based reporting. And all during a seven-minute patient visit.

So what is an "ideal" state moving forward?
The promise of HIT is the ability to use delivered, structured, codified clinical data in a way that offers meaningful clinical decision support to physicians.

In fact, the scope is larger than that. Given the busy nature of today's practices, this support can help spread responsibilities to the most appropriate healthcare providers. For instance, tools may identify a need for a mammogram—which then triggers tasks for a referral specialist to manage. Then that referral, along with the patient's information, can be sent electronically to the specialist of the patient's choice.

What's more, all of this data can generate quality measurement information that can be delivered to health systems to demonstrate the value of the care received and to establish benchmarks in care.

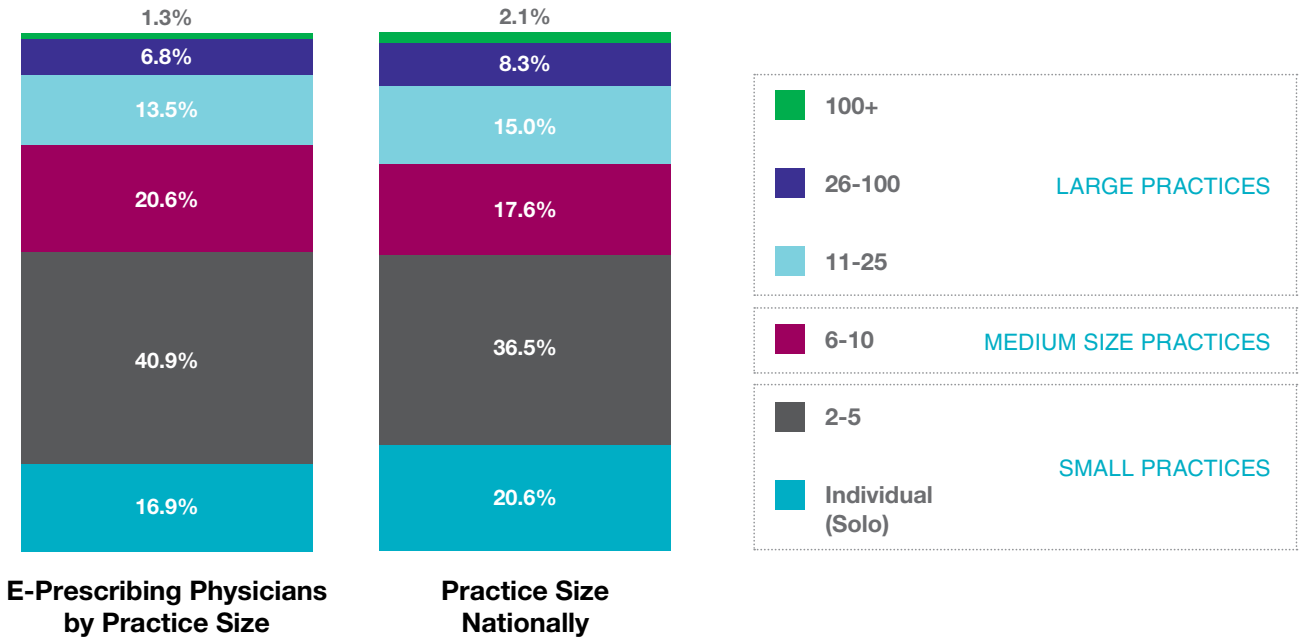
And how is e-prescribing related to all this?
E-prescribing has not just built efficiency within the prescribing system, it has demonstrated the value of clinical messaging. But overall e-prescribing has been a real success story and I think it's because it's been built on a very strong business model. Practices can see the value that replacing paper and fax with electronic communication has brought. Once this value is seen by the practices that start to use it, other physicians can be brought along.

Now with the need for broader types of clinical messaging we have the opportunity to learn from the e-prescribing model and leverage it toward new types of networking that can exchange a broader range of clinical information electronically.

PART 2: ELECTRONIC PRESCRIBING ADOPTION

E-PRESCRIBING PHYSICIANS BY PRACTICE SIZE

Surescripts estimates that physicians e-prescribing through the Surescripts network are representative of the following practice sizes.[13]



PRACTICES WITH 2 TO 10 PHYSICIANS LEAD E-PRESCRIBING ADOPTION

E-Prescribing Adoption by Practice Size

Practice Size	% Active E-Prescribers	% EHR Users
100+	21.9%	99.3%
26–100	30.7%	93.3%
11–25	33.6%	84.5%
6–10	43.5%	79.9%
2–5	41.7%	73.8%
Individual (Solo)	30.6%	63.5%

13 Estimate based on sample analysis of 141,000 prescribers (or 71% of all active e-prescribers) over the Surescripts network as of December 2010.

PHARMACIES—COMMUNITY AND MAIL ORDER

There are approximately 62,000 community pharmacies in the United States, representing both chain and independently owned pharmacies.[14] Of these, about 65 percent are chain pharmacies and 35 percent are independently owned (including those that are part of buying groups). In addition, PBMs and some chain pharmacies operate mail order pharmacies. Surescripts works with these pharmacies to provide prescription routing connectivity with prescribers—the ability to send new prescriptions electronically to the computer system at the pharmacy of the patient's choice and the ability for pharmacies to send prescription renewal requests to the practices' e-prescribing software for their review and electronic response.

KEY STATISTICS

- At the end of 2010, approximately 91 percent of community pharmacies in the U.S. were connected for prescription routing and six of the largest mail order pharmacies were able to receive prescriptions electronically.[15,16]
- More than 98 percent of chain pharmacies and 73 percent of independent pharmacies were connected to the Surescripts network for prescription routing in 2010.

91% OF THE NATION'S COMMUNITY PHARMACIES NOW ACCEPT E-PRESCRIPTIONS

Community Pharmacies Connected for Prescription Routing

Supporting Data

Community Pharmacies Connected:	76%	85%	91%
Independent Pharmacies Connected:	46%	62%	73%

14 Based on NCPDP data analysis.
15 Note: In addition to retail and mail order pharmacies, Surescripts also connects some pharmacies associated with federal and state governments and with medical device manufacturers. For a list of e-prescribing pharmacies, go to www.surescripts.com/connected-pharmacies.html.
16 CVS Caremark, Express Scripts (WellPoint, NextRx), Medco Health Services, Prescription Solutions, Prime Therapeutics (Prime Mail) and Walgreens Mail Service.

PART 2: ELECTRONIC PRESCRIBING ADOPTION

E-PRESCRIBERS IN 19 STATES CAN NOW ACCESS PRESCRIPTION INFORMATION FOR MORE THAN 70% OF PATIENTS

PAYERS

The nation's public and private payers and their associated pharmacy benefit managers (PBMs) provide prescription benefit and medication history information to help inform prescribers when they select medication therapy. Surescripts gives prescribers access to this information through its electronic connections to PBMs, which represent connections to thousands of health plans.

For a list of payers and PBMs that are connected to Surescripts, please visit http://www.surescripts.com/about-us/connected-payers.aspx.

KEY STATISTICS

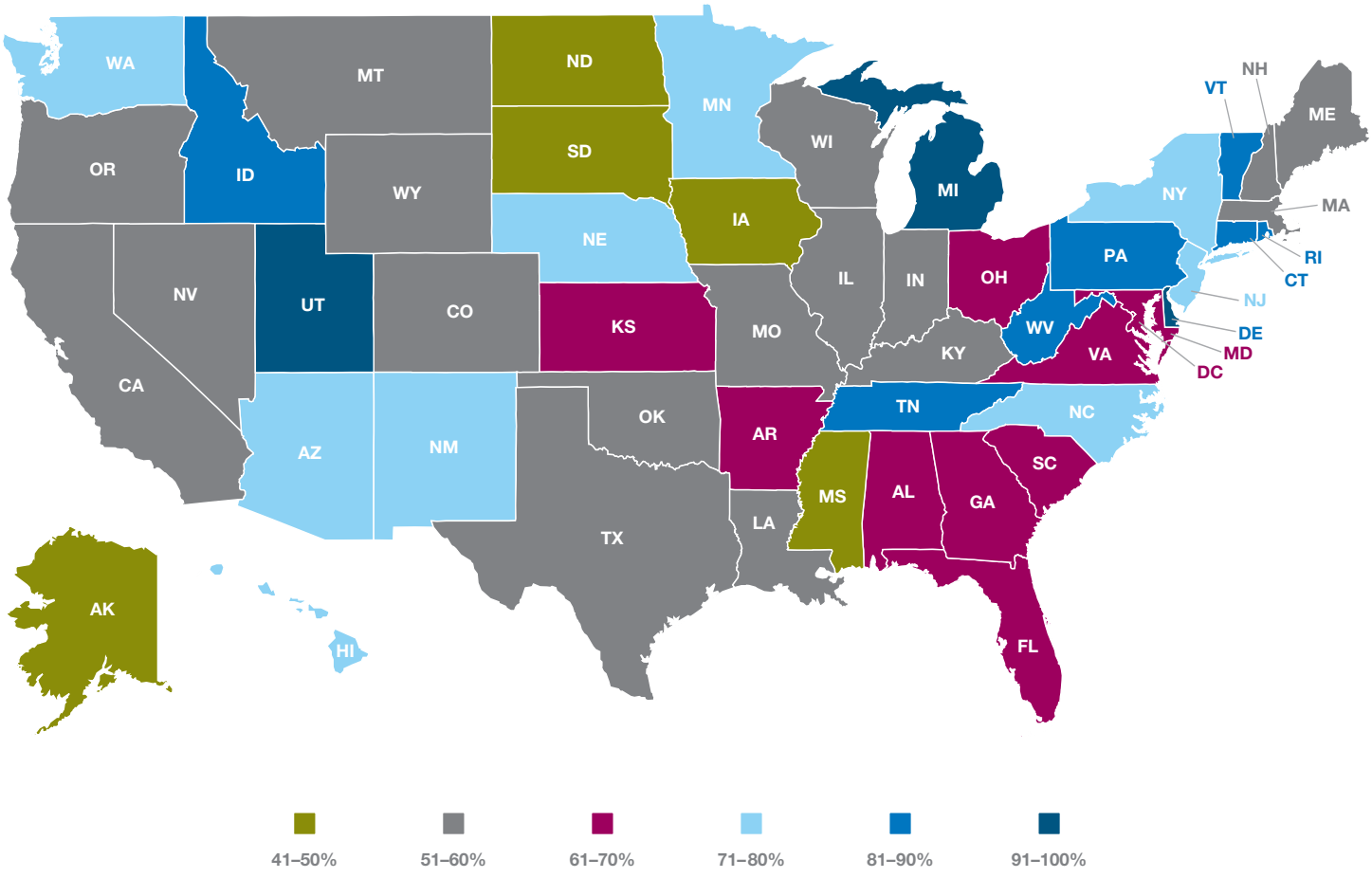
- At the end of 2010, Surescripts was able to provide access to prescription benefit and medication history information (on behalf of payers and pharmacies) for more than 66 percent of patients in the U.S.[17,18]
- By the end of 2010, participation by payers in e-prescribing allowed prescribers to locate and access more than 250 million member records from participating health plans.[19]
- In 2010, Surescripts provided access to more than 30,000 formulary files, including formulary status, coverage, co-pay and alternative medication lists maintained by participating health plans.

17 Calculated by taking the number of records, less 19 percent for patients who have more than one source of prescription benefit coverage, and dividing it by the U.S. population figure of 309 million. Figures include the District of Columbia, Puerto Rico and U.S. territories. U.S. population figures are from *Annual Estimates of the Resident Population for the United States and Puerto Rico,* Population Division, U.S. Census Bureau Release, July 1, 2010.

18 Surescripts suggests that payers can provide a medication history for an estimated 95 percent of the patients for whom it can provide prescription benefit information. This is because some pharmacy benefits, when offered as a carve-out, are not associated with a claims-based medication history.

19 This figure is inclusive of records from all 50 U.S. states and the District of Columbia.

PERCENTAGE OF PATIENTS FOR WHOM PAYERS CAN PROVIDE PRESCRIPTION BENEFIT AND MEDICATION HISTORY INFORMATION



PART 3: INDUSTRY DRIVERS

DRIVERS OF INTEROPERABLE HEALTHCARE IN 2010

HITECH AND THE GROWTH OF E-PRESCRIBING

Federal incentives had significant influence on the number of prescribers who use e-prescribing.

HITECH incentives were one of the most significant drivers of growth in 2010—especially for e-prescribing. 2011 will be a year with increased focus on utilization measurement.

The Health Information Technology for Economic and Clinical Health (HITECH) Act is a key component of the American Recovery and Reinvestment Act of 2009 (ARRA). The main goal of the HITECH Act is to encourage the adoption and meaningful use of electronic health records (EHRs) through incentive payments to physicians and hospitals.

Under the Act, eligible prescribers can receive incentive payments by meeting qualitative and quantitative standards for the meaningful use of a certified EHR, starting in 2011. As specified by the HITECH Act, e-prescribing is a key component of meaningful use requirements, including a mandatory requirement that EHR systems must be capable of electronic prescription routing to pharmacies, and that 40 percent of eligible prescriptions be sent in this manner during a reporting period.

Per federal rules released in July 2010, meaningful use is structured in three phases:

1) Capturing and sharing of data—current phase, Phase I (2011)
2) Advanced-care processes with decision support—Phase II (2013)
3) Improved outcomes and population management—Phase III (2014–2015)

The Act also makes provisions for incentive payments to support the acquisition and use of certified EHR technology for prescribers who treat high volumes of Medicaid patients. It also makes federal matching funds available for some state Medicaid plans for programs that encourage the adoption and use of EHR technology.

According to survey data released by the Office of the National Coordinator for Health Information Technology in January 2011, 81 percent of the nation's hospitals and 41 percent of office-based physicians intend to take advantage of federal incentive payments to increase their adoption and meaningful use of certified EHR technology.

Though ARRA incentives are expected to cover only a fraction of the costs involved in providing this technology, expected gains in efficiency and the potential for fewer adverse drug events promise to provide additional financial incentives for participants to make up the difference. For instance, a 2010 McKinsey report[20] suggests that the broad use of EHRs could lead to a combined savings of more than $30 billion for hospitals alone.

20 McKinsey Quarterly Report—Reforming Hospitals with IT Investment—August 2010.

THE MIPPA E-PRESCRIBING INCENTIVE PROGRAM

Despite HITECH's greater visibility, the MIPPA incentive programs remained a key driver of e-prescribing growth in 2010—particularly for non-EHR practices.

The Medicare Improvements for Patients and Providers Act (MIPPA)—introduced in 2009—offered a 2 percent bonus payment in 2010 for qualified e-prescribers that prepared and sent prescriptions to pharmacies electronically using a qualified e-prescribing system. Such systems could be imbedded in a practice's EHR, or used as a standalone application.

Such reimbursement levels are offered through 2013, with the maximum of 2 percent available in 2009 and 2010. Reimbursement will fall to 1.5 percent in 2011, 1 percent in 2012 and 0.5 percent in 2013. MIPPA also creates a penalty for prescribers who do not start using e-prescribing by 2012. Specifically, those prescribers will suffer a penalty on their Medicare reimbursements rates starting at 1 percent.

Given MIPPA's inclusion of both EHR-based and standalone e-prescribing technology as "qualified systems" under program requirements, MIPPA provides a way for practices to see the benefits of e-prescribing and benefit from incentive monies without a significant capital outlay.

The looming penalties in 2012 will be of concern to non-adopting practices and will influence acquisition of prescribing technology through 2011. That being said, practices should be reassured by the fact that requirements for compliance are relatively low. For instance, practices are only required to send 10 prescriptions electronically during Medicare visits in the first six months of 2011 to avoid MIPPA financial penalties for non-compliance in 2012, and only 25 during all of 2011 to avoid MIPPA financial penalties in 2013. Sending 25 prescriptions electronically in 2011 also qualifies practices for MIPPA financial incentives for the year.

PART 3: INDUSTRY DRIVERS

FOCUS: INTEROPERABLE HEALTHCARE AND THE IMPACT OF UPCOMING MEANINGFUL USE REQUIREMENTS

Requirements for e-prescribing under meaningful use will drive utilization through 2015. Watch for the impact of initial reporting deadlines by October 1, of 2011.

Under current Stage 1 meaningful use requirements, 40 percent of eligible prescriptions must be routed electronically to pharmacies. Participating physicians must demonstrate that they have met this standard to receive incentive dollars—making the measurement of e-prescribing use an important factor of program involvement.

In order to maximize potential incentive payments, physicians must file to receive benefits in 2011 or 2012. Since "demonstrated use" must progress for at least 90 days in a calendar year to be eligible, the 2011 deadline is September 30.

Proposed Phase 2 and Phase 3 meaningful use requirements will place increasing responsibilities on physicians to manage prescriptions electronically and to take advantage of available prescription benefit and medication history information that is able to be delivered to them electronically.[21] Requirements include:

- Routing of at least 50 percent of eligible electronic prescriptions to pharmacies in Stage 2 and 80 percent in Stage 3
- Use of electronically delivered prescription benefit information (patient formulary and benefits eligibility) to inform prescribing decisions
- Access to patient medication history information
- Electronic sharing of clinical information

For those who wish to take advantage of HITECH incentive dollars, the window to adopt electronic health record technology with full e-prescribing capabilities is closing. Physicians begin to lose opportunities to receive these financial incentives in 2013. Starting in 2015, penalties for non-adoption will begin.

21 HIT Policy Committee, Proposed Meaningful Use Stage 2/3 Requirements for Comment—http://healthit.hhs.gov/media/faca/MU_RFC%20_2011-01-12_final.pdf.

FOCUS: EHR CERTIFICATION

The infrastructure is now in place to allow physicians to identify/confirm eligibility of particular EHR systems under HITECH.

Any EHR technology adopted under HITECH must complete a certification process designed to ensure that a particular system has the capabilities to allow participating physicians to meet meaningful use requirements. These include the ability to manage prescription information electronically.

In 2010, five organizations were designated by the Office of the National Coordinator for Healthcare Information Technology to certify these technologies. The federal government is keeping an updated list of products that have been certified, with over 200 listed at the end of 2010.

This listing may be found at http://onc-chpl.force.com/ehrcert. Products are certified as complete EHRs or modular systems, and linked to specific certification criteria. A specific ONC certification number is granted to each certified system which is essential to document in order to receive incentive payments.

In early 2011, Surescripts joined the list of organizations that have been granted ONC ATCB status. Surescripts is able to certify that e-prescribing functionality meets the requirements of the HITECH incentive program.

PART 3: INDUSTRY DRIVERS

FUTURE DRIVERS OF INTEROPERABLE HEALTHCARE GROWTH

IMPACT OF HEALTHCARE REFORM

Beyond incentive dollars, PPAC provisions are driving use of health information technology.

Under the rubric of healthcare reform, the Patient Protection and Affordable Care (PPAC) Act carries certain key provisions that helped drive the adoption of healthcare technology in 2010 and will continue to drive adoption and use during the next three to five years. These factors include:

(i) Potential growth in the number of insured patients:

The PPAC Act suggests that 30 million additional lives will be covered over time. With increased demand for services, and pressure to shift reimbursement models from a volume basis to a value basis, Health IT demand from practices, hospitals and health systems will strengthen. This is particularly relevant with systems that enable stronger provider communication and access to timely, relevant clinical data and coverage information. The need for advanced electronic tools to manage claims-related data will be felt by payers too as their volume of claims increases. Lastly, an increased volume of office visits is expected to have a proportional effect on prescribing volume, with more prescriptions than ever before making their way to community and mail order pharmacies.

(ii) Adjusted expense ratios for insurers:

In October 2010, the National Association of Insurance Commissioners announced that certain IT expenses can be included as medical expenses when calculating an insurer's medical loss ratio under the PPAC. Under the Act, as of January 1, 2011, insurers will be required to spend 85 percent of large-group premiums and 80 percent of small-group and individual plan premiums (with certain adjustments) on healthcare, or to improve healthcare quality or return the difference to the customer as a rebate.

Expenditures made to facilitate communications between healthcare providers and their patients can fall under the 80–85 percent expense ratio—thereby encouraging investment in health information technology that can manage these communications electronically and thus increase the potential for quality improvements and efficiencies through streamlined workflow and the timely delivery of more robust clinical information.

ELECTRONIC PRESCRIBING OF CONTROLLED SUBSTANCES

Prescribers have long dealt with dual workflows due to the need to maintain paper- and fax-based prescribing for controlled substances. Now DEA regulations offer the opportunity to manage these prescriptions electronically.

Starting June 1, 2010, the U.S. Drug Enforcement Administration (DEA) allowed prescribers the option of issuing prescriptions for controlled medications electronically, subject to requirements specified in the DEA's Interim Final Rule (IFR), published in the March 31, 2010 issue of the *Federal Register*.

By establishing a framework by which prescribers can manage controlled substances electronically, the DEA provides a path for prescribers to manage all their prescriptions within an electronic workflow, rather than forcing them to maintain parallel processes—paper- and fax-based methods for controlled substances and electronic processes for all other medications.

In order to electronically prescribe controlled substances (EPCS), prescribers must adhere to the following key DEA regulations:

1) They must use an e-prescribing application that is certified for this purpose.
2) They must complete an identity proofing process.
3) They must use a two-factor authentication process each time one of these prescriptions is issued.

Two-Factor Authentication Defined

In addition to the use of an existing security feature within an e-prescribing application, prescribers must use a separate and distinct security feature to prescribe controlled substances. This could be a "hard token" such as a radio frequency identification device, a password from an independent password generator and so on.

With this it is expected that educational efforts must be undertaken to ensure that prescribers are comfortable with the workflow adjustments and hardware acquisition that are necessary to prescribe these medications electronically.

Surescripts has expressed its commitment to readying its network operations to supporting EPCS.

Surescripts' own research has suggested that prescribers have a strong desire to prescribe controlled substances electronically, with the consideration that new workflow processes needed to comply with DEA regulations will have an impact on adoption. Results from a fall 2010 prescriber survey conducted by Surescripts show that:

- Approximately three-quarters of prescribers are highly aware that the DEA now permits EPCS
- An equal proportion (74 percent) has a high degree of interest in EPCS
- The majority of prescribers—56 percent—want to prescribe controlled substances electronically as soon as possible once the service becomes available to them

Unfortunately, when presented with details regarding the DEA's ID-proofing requirements, prescribers with a high degree of interest in EPCS dropped from 74 percent to 56 percent.

These findings were consistent across practice sizes and most specialties. A higher degree of interest was shown by those in specialties who issue a higher proportion of prescriptions for controlled medications, such as psychiatry.

This suggests that a degree of care must be taken to put DEA requirements into proper context and to provide a clear workplan for the adoption and use of additional technologies required to be in compliance. This includes offering a variety of options for two-factor authentication to ensure that prescribers can select one that is best for their office workflows.

PART 3: RECOMMENDATIONS

SUPPORTING THE CONTINUED GROWTH OF INTEROPERABLE HEALTHCARE

Each year, Surescripts provides a series of recommendations within the *Report* to address issues that we believe need to be rectified to help make e-prescribing and interoperable healthcare standard practice. Our 2010 recommendations are summarized below.

Drive utilization. Continue to develop programs that focus on driving the utilization of e-prescribing and interoperable healthcare technologies.

Bridge adoption gaps. Government and industry must collaborate to address gaps in adoption by solo practitioners, independently owned pharmacies and state Medicaid programs.

Promote clinical collaboration. Support emerging models of collaborative care.

1. FOCUS ON UTILIZATION

Status: Continued Identified Need—Carryover from 2009 National Progress Report

2010 Assessment

Recent studies show that the use of e-prescribing within EHR systems continues to be sub-optimal. According to the Center for the Study of Health System Change,[22] of the 44 percent of physicians who report using EHRs (in part or in full), only 42 percent reported using an e-prescribing prescribing system.

Of these:

- 23% do not use it routinely
- 65% use it to check for adverse drug events (ADEs)
- 54% use it to transmit prescriptions to pharmacies electronically
- 34% use formulary features
- 23% use all features regularly

Recommended Actions

If e-prescribers are to achieve acceptable standards of utilization—with the most immediate need being the achievement of Phase 1 meaningful use requirements (at least 40 percent of eligible prescriptions are managed electronically)—public and private interests must provide the education and tools needed to do so.

Recommended actions include:

- Benchmarking data to assist prescribers in assessing system performance in relation to others in their area and against meaningful use requirements
- Definitive best practices with respect to user interfaces, data delivery and interpretation with associated certification
- Increased role of Regional Extension Centers to support such education

22 HSC 2008 Health Tracking Physician Survey

PART 3: RECOMMENDATIONS

SUPPORTING THE CONTINUED GROWTH OF INTEROPERABLE HEALTHCARE

2. CLOSE GAPS IN ADOPTION

Status: Continued Identified Need—Carryover from 2009 National Progress Report

2010 Assessment	Recommended Actions
Solo Practitioners: Although HITECH incentive programs are providing an impetus for solo practitioners to adopt electronic health record technology, the ability to recover the cost of implementing such technology is often hampered by lack of specialized IT staff who can support its implementation, and the time and training resources needed to support ongoing use.	Solo practitioners should be a special focus for educational and technical support programs led by payers, health systems and Regional Extension Centers to ensure that implementing and using such technologies happen in a way that minimizes workflow impact, especially during the first few months after its introduction.
Independently Owned Pharmacies: Compared with chain pharmacies, independents have adopted e-prescribing at a slower pace. The gap between independent/chain growth in e-prescribing connectivity has closed in the past year, but not to the extent that it can be considered equal. Given the strong relationships that independent pharmacies often have with prescribers in their communities, their connectivity is important to promote more consistent prescribing workflows in the practice setting.	State, private and local programs already working to encourage the adoption of health technologies must remember the independent pharmacy, as programs in North Carolina and New York have already done. Independent pharmacies in these states have adopted e-prescribing at a rate that is 15 percent and 10 percent higher—respectively—than the national average.
State Medicaid Programs: At the end of 2009, nine state Medicaid programs were able to provide eligibility and formulary information to prescribers electronically, with another seven in process. By the end of 2010, this figure had risen to 15 and five, respectively. While this demonstrates good progress, 30 state Medicaid programs have not yet made efforts to establish this connection.	Any Medicaid program that has not yet undertaken planning to electronically provide prescription benefit information to prescribers in their respective states should take steps to do so. This will involve both state and federal legislative support and potentially incentives to encourage participation.

3. SUPPORT EMERGING MODELS OF COLLABORATIVE CARE

Status: New for Report

2010 Assessment

The concept of patient-centered medical homes (PCMHs) and accountable care organizations (ACOs) promises better use of resources to enhance patient outcomes over time through a shift from quantity-based to quality-based medical care. Under these models, inpatient and outpatient care is coordinated among all physicians treating a patient. Compensation is based on the overall progression of patient responsiveness to assigned therapies versus a panel of patients with similar conditions.

As care broadens in this respect, reliance on health information technology to facilitate this communication becomes more and more important. The Centers for Medicare and Medicaid Services itself stated that the use of electronic health records with information-exchange capabilities (such as clinical decision support and access to the patient's medical records, lab results and medication history) was key to success as an ACO. This is understandable given that estimates suggest that the average Medicare patient sees seven physicians over a two-year period.[23]

Recommended Actions

Quality-driven collaborative care requires both the software technologies to store and interpret clinical information and the networking support to ensure smooth, effective communications among all participants in patient care.

This suggests both an expectation that regionally based networks developed by integrated delivery networks and health information exchanges will grow, and a limitation that will be faced by these same networks to develop effective networking communication with all needed participants in patient care.

Such technologies must ensure interoperability to leverage existing private and regional networks provided by health information exchanges, integrated delivery networks and electronic health record providers, and to provide access points for those who have no access.

23 2 primary, 5 specialty in 4 practices—Core Patterns in Medicare and Their Implications for Pay for Performance, *New England Journal of Medicine,* March 15, 2007.

PART 3: ABOUT SURESCRIPTS

The Surescripts network supports the most comprehensive ecosystem of healthcare organizations nationwide. Pharmacies, payers, pharmacy benefit managers (PBMs), physicians, hospitals, health information exchanges and health technology firms rely on Surescripts to more easily and securely share health information.

Guided by the principles of neutrality, transparency, physician and patient choice, open standards, collaboration and privacy, Surescripts operates the nation's largest health information network. By providing that information for routine, recurring and emergency care, Surescripts is committed to saving lives, improving efficiency and reducing the cost of healthcare for all.

For more information, go to www.surescripts.com and follow us at twitter.com/surescripts.

WHY WE ISSUE THIS REPORT

With more than 34 percent of the nation's prescribers, 91 percent of the nation's community pharmacies and the nations' leading PBMs, payers and mail-order pharmacies managing prescriptions electronically through the Surescripts network, Surescripts can track important trends in the adoption and use of prescribing technologies. As of 2010, e-prescribing has become our nation's most commonly electronically exchanged form of clinical information.

With this unique vantage point, and driven by our corporate commitment to neutrality and transparency, Surescripts has issued the annual *National Progress Reports on E-Prescribing* since 2008. Through this comprehensive report, we hope to show that the growth of e-prescribing adoption—and more important, its sustained use—can offer the industry an important bellwether for the adoption and use of health information technology as a whole.

And with the addition of network capabilities that support interoperable clinical communication between healthcare providers, Surescripts will expand this report moving forward to examine a broader range of data covering networked healthcare.

THE SURESCRIPTS ELECTRONIC PRESCRIBING NETWORK

Surescripts connects prescribers in all 50 states—through their choice of certified e-prescribing software—to the nation's leading payers, chain pharmacies and independent pharmacies.

Any e-prescribing software provider—including those offering standalone e-prescribing solutions and those that integrate e-prescribing capabilities into electronic health record systems—may connect their customers to Surescripts' secure nationwide e-prescription network, as long as they have completed Surescripts' certification process. This process validates that the certified software is able to send and receive electronic messages in accordance with industry standards.

Surescripts certifies software used by prescribers, pharmacies and payers/PBMs for access to three main services: Prescription Benefit, Medication History and Prescription Routing.

PRESCRIPTION BENEFIT SERVICES

Prescription Benefit—Ambulatory	Allows prescribers to request information on patient eligibility and formulary at the time of prescribing.
Eligibility Services—Pharmacy	Allows pharmacies to check patient eligibility, in real time, at the point of sale.
Eligibility Services—Medicaid	Allows Medicaid MMIS vendors to request pharmacy eligibility, in real time, from Surescripts before adjudicating a claim.

MEDICATION HISTORY SERVICES

Medication History—Ambulatory	With a patient's permission, this service allows prescribers to securely access aggregated medication history data from community pharmacies and patient medication claims history from payers and PBMs.
Medication History—Acute	Allows prescribers and authorized staff in acute-care settings to query and receive aggregated details for up to a year's worth of patient medication history from payer and pharmacy records representing over 240 million patients.
Medication History—Personal Health Records (PHRs)	Allows patients who use select PHR technologies to receive their medication history information from retail pharmacies.

PRESCRIPTION ROUTING SERVICE

Surescripts' Prescription Routing service allows prescribers to prepare and send a prescription directly to the computer at 91 percent of the nation's retail pharmacies, and six of the nation's largest mail order pharmacies. In turn, pharmacies can use this service to send requests for prescription renewals directly to the computer at a practice so that prescribers can review and respond to them directly.

PART 3: ABOUT SURESCRIPTS

THE SURESCRIPTS NETWORK FOR CLINICAL INTEROPERABILITY

In October 2010, Surescripts announced that it was expanding its network operations to establish the Surescripts Network for Clinical Interoperability™—a common and neutral point of connection to facilitate the secure exchange of clinical information between all types of healthcare providers.

This new network leverages Surescripts' significant experience and business approach to electronic clinical message exchange to allow healthcare providers to exchange a wide array of clinical information—peer to peer—regardless of network affiliation or use of technology.

With its neutral approach to connectivity Surescripts NCI acts as a "network of networks"—permitting health systems, health information exchanges and electronic health record providers to connect their affiliated clinicians to their peers both locally and nationwide. This single point of access avoids the need to establish complex individual network connections and allows clinicians to maintain their relationship and user experience with their existing network solutions.

Connectivity to the Surescripts Network for Clinical Interoperability can be achieved through a suite of connectivity tools designed for flexible implementation and integration.

The Surescripts Network for Clinical Interoperability supports transmission of a full range of clinical information:

- Discharge summaries
- Referrals
- Medication histories
- Continuity of care documents
- Structured and unstructured notes
- Lab results
- Immunization records

Using a variety of protocols:

Including Surescripts' network standards, Direct and NHIN Exchange Projects, HL7, and other meaningful use standards as they develop

Supported by Surescripts' established network services:

- Network Infrastructure
- Certification & Compliance
- Directory Management
- Customer Support & Education
- Security & Authentication
- Implementation

SURESCRIPTS' CLINICAL INTEROPERABILITY TOOLSET

1) Surescripts Net2Net Connect	This tool allows network and technology providers to build a direct connection to Surescripts' national network.
2) Surescripts Message Stream	Offers all certified network connectivity services of Net2Net Connect and adds a rich set of management and storage tools applicable for internal and/or external communication.
3) Surescripts Clinical Messaging Portal	A simple, secure, browser-based portal for clinical interoperability that provides basic, reliable communication between providers through secure portal technology. Designed for those who do not have access to existing network-connected technology or for network providers who wish to provide an interim connectivity solution for their clients.

SURESCRIPTS—VALUE-ADDED NETWORK SERVICES

In order to ensure the success of our health information network, Surescripts provides many services free of charge, including:

- **Certification—**Surescripts implements and consistently applies open standards for certification and implementation of technology systems.
- **Compliance—**Surescripts conducts audits of technology vendors and connected entities to ensure compliance with standards and commitments for connectivity.
- **Standards Development—**Surescripts works with NCPDP, CCHIT, HITSP and other standards bodies to develop, evolve and certify against industry technical standards.
- **Education and Collaboration—**Surescripts engages with national, state and regional entities, both public and private, to develop educational programs, adoption and utilization programs, quality initiatives, and dialogue to support ongoing growth in the adoption and meaningful use of e-prescribing and health IT.
- **Support—**Surescripts provides technical assistance and resources to support physicians, pharmacies, payers and vendors through its account team and its Electronic Prescribing Resource Center.
- **Monthly Participant Calls and Biannual Participant Workshops—**Surescripts hosts regular events with network participants to inform them of developments and best practices around e-prescribing.
- **Pilot Programs—**Surescripts participates in and supports CMS, AHRQ and other public/private pilot programs.

ACKNOWLEDGMENTS

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For more information about Surescripts, visit **www.surescripts.com** and follow us at **twitter.com/surescripts.**

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Topical Review

Electronic Prescribing of Controlled Substances (EPCS)

June 20, 2011

Controlled substances can now be legally prescribed electronically, once specific criteria [1]are met. States across the country are working to adapt regulations to accommodate this rule, vendors are changing their products, and new groups are stepping forward to help create the needed infrastructure. Electronic prescribing of controlled substances is coming, but is not ready for clinician use just yet. This tool offers advice for getting the medical office or pharmacy ready, current best practices for managing controlled substances, and the projected changes in best practices based on the present legislation.

Getting Ready for Electronic Prescribing of Controlled Substances: Medical Office

1. Evaluate the relative impact of EPCS for your office by surveying the number of controlled substance prescriptions currently handled in a day, week, or month.
    a. If more than 30% of prescriptions are controlled substances, consider implementing most, if not all, of the following suggestions.
    b. If 10% to 30% of prescriptions are controlled substances, consider implementing the top 3 of the following suggestions most appropriate to your practice.
    c. If less than 10% of prescriptions are controlled substances, consider implementing one or 2 of the following suggestions most appropriate to your practice.
2. Choose an e-prescribing application that is certified for EPCS by a DEA[2]-approved authority. Each prescriber of controlled substances will need 2-factor authentication credentials.
    a. With your software vendors, identify the timeline on which this certification or audit is expected to be completed. This determines the date you can begin using EPCS.
3. Reshape workflows that leverage time freed up for office staff to balance the additional prescriber time needed for EPCS. Work with your vendor to answer:
        i. How should refills be handled?
        ii. Who has the ability to approve CS[3] prescriptions and send them to the pharmacy?
        iii. How does the system prevent or limit fraud or misuse by staff?
        iv. How should prescribers and staff educate patients on changes that e-prescribing brings?
4. Acclimate patients to calling the pharmacy for renewal requests of non-controlled substances. When EPCS is available, the transition to calling the pharmacy for controlled substances will be seamless.
5. Create a document defining the conditions for a patient requesting a renewal for a controlled substance that should prompt a referral and discussion to the prescriber. After EPCS is ready, share this document with the top twenty pharmacies to which these prescriptions are sent.

[1] As defined in 21 CFR Parts 1300, 1304, 1306, and 1311
[2] DEA = Drug Enforcement Administration
[3] CS = Controlled Substances

6. Script a patient education process for the staff to review with patients. This script should include the best way to request a renewal after patients receive a prescription for controlled substances.
7. Add e-prescribing training to the orientation of new employees that have prescription responsibilities.

***Note**: If a transmission of EPCS fails, current regulations for a paper prescription of CS should be followed.*

Getting Ready for Electronic Prescribing of Controlled Substances: Pharmacy

1. Use electronic communication tools to provide more detailed communications to medical offices when resolving or anticipating questions regarding non-controlled substances.
2. Create a document defining the conditions that warrant a referral of a patient to their provider for further evaluation. After EPCS is ready, share this with your top twenty medical offices. Keep a copy on hand for ad hoc requests.
3. Script a patient education process for pharmacy staff to review with patients on the best way to request a renewal.
4. Instruct patients to call for refills and renewals for all prescriptions.
    a. Choose or upgrade the pharmacy software to include an e-prescribing module that is certified for EPCS by a DEA-approved authority. Each pharmacist may need 2-factor authentication credentials, but this has not yet been finalized.
5. Work with your vendor to educate staff regarding processes that change as a result of e-Prescribing controlled substances.
6. Work with prescribers to establish an understanding of usual time frames needed to process renewal requests, any additional information prescribers may need along with the request, and conditions that would prompt a patient to make an appointment with their provider for a renewal.
7. Incorporate controlled substance legal requirements into the standard medication counseling. Provide patients with reasonable expectations regarding the process for requesting renewals and define the scenarios where the patient must see their primary care provider.

References and Further Information

Full legal text of the interim final rule for electronic prescribing of controlled substances:
http://www.deadiversion.usdoj.gov/fed_regs/rules/2010/fr0331.pdf

Q&A for EPCS: http://www.deadiversion.usdoj.gov/ecomm/e_rx/faq/faq.htm

Rationale for pharmacists in the medical home model:
http://www.cshp.org/uploads/file/Newsroom/2010/why_pharmacists_belong_in_med_home_5_2010.pdf

Episode #14: Complexities of e-Prescribing: Physician and Pharmacist Viewpoints:

http://www.himss.org/ASP/physicianCommunityPodcast.asp

Renewal Requests

Bottom Line: Work shifts from office staff to the prescriber

Current Best Practice:	Expected change after EPCS:
• Patients call the prescriber's office to request renewals; *OR* • Pharmacies fax a renewal request to the prescriber's office; *THEN* • Secretary/Nurse prepares the prescription for prescriber review and authorization. In electronic systems, the prescription is printed instead of sent electronically.	• Patient calls the pharmacy to request renewal. • Pharmacy sends electronic renewal request to the prescriber's office. • Secretary/Nurse prepares the prescription for prescriber review and authorization. The response is sent electronically. ○ If the electronic transaction fails, the prescription is printed, signed, and managed as a paper prescription.

Rationale: The record of previous dispensing allows pharmacists to submit an accurate electronic request for a renewal, decreasing the burden of phone calls on medical office staff. The pharmacist is often in a better position to determine the medication the patient is requesting since the record of previous dispensing limits the possible medications the patient could be requesting. Communication fields in pharmacy software allow for robust notes to accompany the request and facilitate a reply by the prescriber, including whether the patient needs to be seen by their primary care provider before a prescription can be issued.

New Prescriptions

Bottom Line: No big changes in workflow

Current Best Practice	Expected change after EPCS
• The prescriber generates the prescription using an e-prescribing application or writes a paper prescription • The prescription is printed for a wet signature ○ State legislations vary with respect to fax and phone processes	• The prescriber generates the prescription using an e-prescribing application • Then "Signs" the prescription electronically using 2-factor authentication • Then transmits the prescription electronically to the patient's pharmacy of choice.

Rationale: No expected workflow changes as the prescriber is the primary actor in the current best practice and is expected to remain so after EPCS.

EPCS Documentation

Bottom Line: Automatic documentation is balanced against more documentation

Current Best Practice	Expected change after EPCS

• Prescriptions for controlled substances are documented in the chart as to:
  ○ Drug
  ○ Quantity
  ○ Directions
  ○ Start and stop dates
• Some documentation of prescriptions for the chronic patient may be delegated
• Ideally, documentation is in the chart that the patient is aware that deviations from the normal pattern of use will result in appropriate penalties.
	• If the prescriber already has an EMR[4], the documentation of controlled substances does not change much.
	• There will likely be a new step in the clinic's workflow: a check to see if the patient already has a prescription (from another pharmacy and/or from another physician) for a given CS prescription.
	  ○ These kinds of databases are already available in some states (e.g., Ohio); their existence and the form they take will vary from state to state.

Electronic documentation in both pharmacy and prescriber's office makes information surrounding the CS prescription more available. Though not easily done in today's paper based systems, workflows for checking adherence, timeliness of past fills, pharmacies used, and past prescribers may quickly develop, as much to mitigate the prescriber's and pharmacy's liability as to improve safety and accuracy of care. The advent of EPCS makes these functions much more realistic and accessible.

[4] EMR = Electronic Medical Record

EPCS Patient and Staff Education **Bottom Line:** Work shifts from the prescriber's office to pharmacies	
Current Best Practice	**Expected change after EPCS**
• Patients usually learn about controlled substance requirements in two ways: a. From the pharmacist, when a prescription cannot be filled. b. From practitioners and their staff, when a controlled substance prescription is needed, often prompted by a patient's request for renewal. • Staff may or may not have formal training on the legal requirements of controlled substance prescriptions. The same is true for learning workflows and procedures within the office or pharmacy to educate and instruct patients on the expectations and requirements surrounding controlled substances.	• Counseling and education regarding controlled substance requirements will likely take on a much larger role in the pharmacy while simultaneously decreasing at the provider's office. • Additional formal staff education is needed in places where office staff participates in the electronic prescriptive process. • Accommodations in workflows may be necessary to allow for additional patient instruction time. • Offices may need to restructure workflows to leverage staff freed up from some demands (many renewal requests and CS education tasks will be shunted to the pharmacy) to provide support for prescribers that now have additional demands placed on them (2-factor authentication is required for both new prescriptions and renewal requests)
Rationale: Patients are increasingly being instructed by the practitioner's office to request renewals through the pharmacy. The increased complexity of sending controlled substances electronically requires that prescribers have a prominent role in the final disposition of all controlled substance prescriptions sent electronically, increasing demands for their time while that of their office staff decreases. Pharmacists are in a key position as both requestors of renewal prescriptions and dispensers of the final product to educate the patient regarding the regulations, expectations, and best practices surrounding controlled substances.	

Annotations and Comments

Until the Rules' publication, there was no legal authority for an electronically transmitted controlled substance prescription. This resulted in:

- A complete separation of activities in which controlled substance prescriptions are written on paper while non-controlled substance prescriptions are transmitted electronically.

OR

- A process by which the prescriptions are entered electronically in order to gain the safety checks associated with CPOE[5], but a corresponding paper copy is printed and signed for delivery to the pharmacy in order to handle the regulatory aspect of a legal prescription.
- EPCS aligns the medication order check process more consistently, improves patient satisfaction by reducing different methods by which their medications are dispensed, and affords high traceability of prescriptions through the security requirements defined by DEA.

[5] CPOE = Computerized Physician Order Entry

Topical Review

Electronic Prior Authorizations (ePA)

June 20, 2011

Electronic Prior Authorization technology is coming soon. Standards have already been developed and are currently being revised in anticipation of widespread adoption. This document will help identify current best practices and how those practices may change when this new technology becomes available.

Getting Ready for Electronic Prior Authorizations: Medical Office

1. Invest time to develop a prior authorization workflow that works best for your practice. Consider addressing the following points.
    a. Today, document your current process for prior authorizations and save the work for later use
        i. Who manages the process currently?
        ii. Who starts a prior authorization? Who finishes it? Who delivers it?
    b. When your vendor indicates ePA is on their list of planned upgrades, meet with staff and stakeholders to discuss electronic prior authorizations.
        i. How will ePA change roles and responsibilities?
            1. For example, some e-prescribing workflows shift work from staff to prescribers. Will the staff then be expected to have a larger role with managing ePA?
        ii. How will patients be informed of ePA processes?
            1. Electronic prior authorizations put the medical office prescriber and staff in the best position to provide this education instead of the pharmacy.
        iii. How will communications with the pharmacy change?
        iv. What situations require a change to an approved therapy versus completing the authorization requirements for the intended therapy?
        v. What medications have acceptable alternatives? Under what conditions?
            1. Consider creating a list of acceptable alternatives for staff reference.
    c. When ePA is available, create written protocols for staff and prescribers to use as a guide.
        i. Define how prior authorizations are started from new prescriptions and renewal requests.
        ii. Define responsibilities of staff and prescribers.
        iii. Define how patients will be educated and informed regarding any prior authorization process that affects them.
        iv. Define how new staff and providers will be educated and informed regarding the prior authorization process.
        v. Define how to communicate the office's management of prior authorizations to local pharmacists.
            1. Consider creating an FAQ that can be readily faxed to pharmacies as needed.
2. Use electronic prescribing, preferably in an electronic health record that has formulary alerts.

Getting Ready for Electronic Prior Authorization: Pharmacies

1. Invest time to develop a prior authorization workflow that works best for your pharmacy. Consider addressing the following points
    a. Today, document your current process for prior authorizations
        i. Who manages the process currently? How is it documented? How is it followed up?
    b. When your vendor indicates ePA is on their list of planned upgrades, meet with staff and stakeholders to discuss electronic prior authorizations
        i. How will roles and responsibilities change within the pharmacy? With providers?
        ii. How will patients be informed?
        iii. How will provider interactions change?
        iv. What criteria determine whether a patient is referred to their provider or managed in the pharmacy?
    c. When ePA is available, create written protocols for staff and prescribers to use as a guide
        i. Define responsibilities of staff and pharmacists
        ii. Define how patients will be educated and informed regarding any prior authorization process that affects them
            1. Consider working with local providers to determine whether general expectations fall to pharmacy to provide this education or to the providers
        iii. Define how new staff and providers will be educated and informed regarding the prior authorization process
        iv. Define how to communicate the pharmacy's management of prior authorizations to local providers
            1. Consider creating an FAQ that can be readily faxed to providers and be made available for patients
2. Reach out to local providers to understand their electronic prior authorization processes

References and further information

Brief summary of the state of ePA: http://www.healthit.gov/buzz-blog/from-the-onc-desk/eprescribing-standards-eprior-authorization/

NCPDP progress on ePA standards: http://www.ncpdp.org/PDF/NCPDP_prior_auth_workflow.ppt
http://www.pocp.com/images/pdfs/ePrior_Auth_-_AMCP_-_Final__Final.pdf

Minnesota ePA work: http://www.health.state.mn.us/asa/drugauth122109mtgmat2.pdf

ePA Prescriptions

Bottom Line: Work shifts from the pharmacy to prescribers and staff

Current Best Practice:	Expected change after ePA:

Providers often learn of the need for prior authorization when creating and renewing prescriptions in one of two ways.
• When responding to an electronic renewal request – a formulary alert appears and suggests a prior authorization is needed.
  ○ In offices where support staff is the initial responders to renewal requests, this prior authorization information may be forwarded to the prescriber.
• The prescription is already written and the pharmacy discovers the need for prior authorization when transmitting the claim to the insurer. The pharmacy usually faxes this as a request back to the prescriber for review, which is also mediated by the office support staff. Both paths lead to a common next step: starting the prior authorization process.
In most cases, office staff will initiate or complete the prior authorization form and give it to the prescriber for review and approval. Then, office staff sends the form to the insurer and answer any future pharmacy questions regarding the status of the prior authorization.
	An electronic prior authorization alters the current best practice in several fundamental ways.
	• Responding to an electronic renewal request (or creating a prescription) where prior authorization is required generates a formulary alert. This immediately places the prescriber in a position of reviewing and authorizing the submission of the prior authorization as part of finishing the prescription; alternative medications can be chosen and justifications can be documented.
	  ○ If the ePA cannot be completed at that moment, the prescription itself may be placed on hold until the prior authorization can be resolved.
	• The provider or office staff needs to inform and educate the patient regarding the prior authorization and any prescription delays.
	  ○ In offices where office staff is the initial responders to electronic renewal requests, business rules are needed to define how this prior authorization alert should be handled.
	In some cases, the prescription is already written and the pharmacy discovers the need for prior authorization when transmitting the claim to the insurer, assuming the prescriber's system allowed the prescription to be sent without a completed ePA present. The pharmacy will need to follow up with the insurer or the provider's office staff to determine the status of the ePA.

Rationale: Electronic prior authorizations remove several steps in the prior authorization process. This shifts much of the burden of management to the prescriber while many of the secretarial functions of putting information into a form are now computerized and automatically completed. This shifts the discovery of the need for prior authorization away from the pharmacy to the provider's office, and carries the burden of patient education with it.

ePA Documentation

Bottom Line: Automation helps save time, but work may be assumed for reports and quality assurance.

Current Best Practice:	Expected change after ePA:
• Prior authorizations are generally documented by office staff in a separate binder, as part of the chart, or not at all. • Pharmacists often make notations on the reverse of the prescription to document prior authorization activities, or add an electronic note to the patient's profile.	• Prior authorizations will be recorded in the prescriber's software and may be tagged as approved when they arrive at the pharmacy. • In some electronic health records, this information may also be pushed to other data consumers such as patient portals, HIE[1]'s, and other parts of the patient's internal record. Software vendors will determine the robustness of adhoc documentation available for ePA. • Certain offices may want to use ePA for the generation of reports, suggesting additional work might be taken on by office staff to manage the data reporting. • Reports on ePA activity can be used for quality improvement, measuring outcomes, nonadherence reports, measures of workload, and more. Again, potentially more work assumed.

Rationale

The digitized and archival form of ePA lead immediately to ways the data can be transformed to information. Since the relative accessibility of this information is almost solely determined by vendors, there will likely be a large variety of documentation capability from one product to another. The robustness of documentation options may lead to the assumption of more work by office support staff in the form of reports and quality assurance activities even as automation and workflows shift work to the prescribers.

[1] HIE = Health Information Exchange

ePA Patient and Staff Education

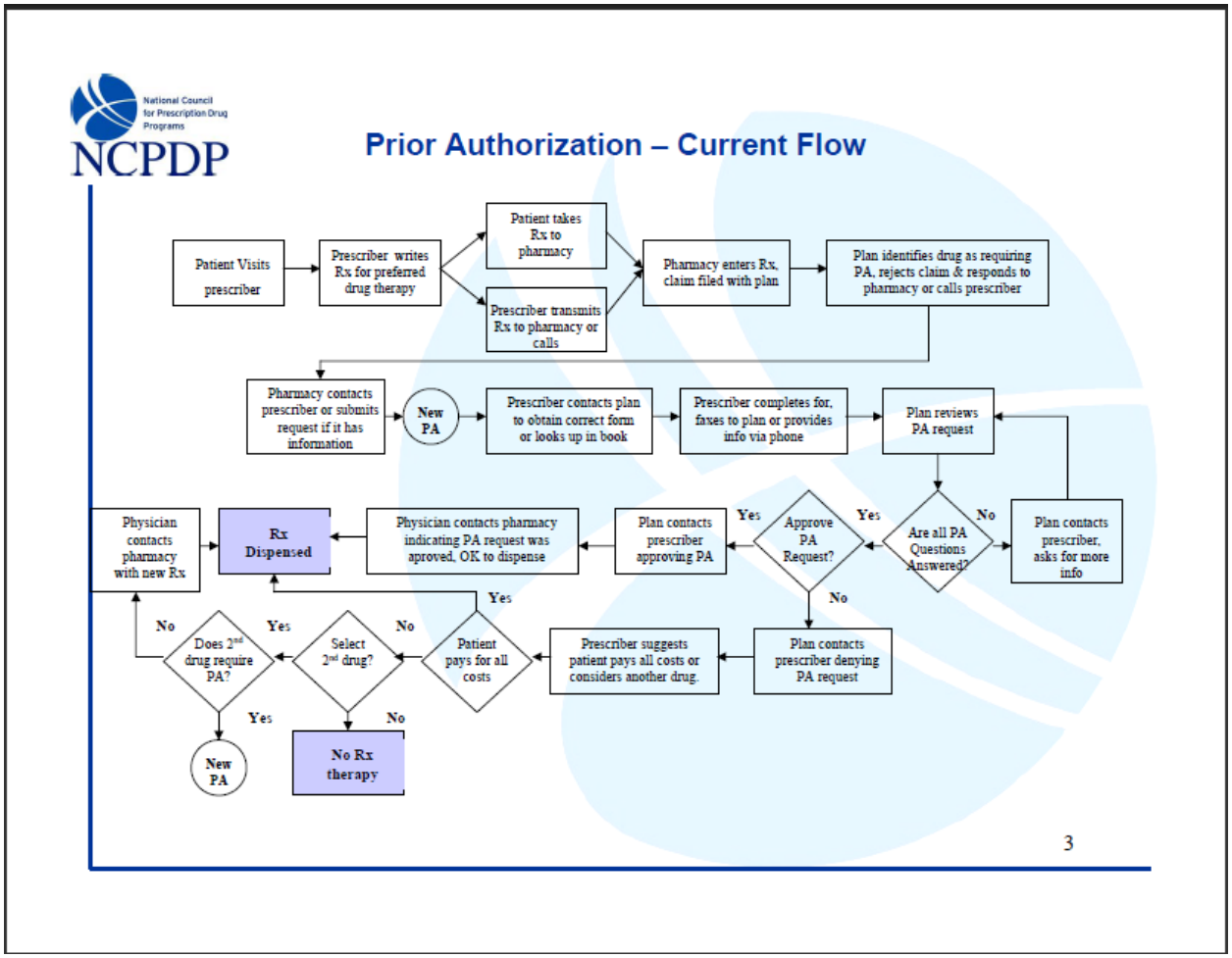
Bottom Line: Work shifts from the pharmacy to the prescriber and office staff.

Current Best Practice:	Expected change after ePA:
Patients learn about prior authorizations most often when there is a delay in getting their medication. In a rough order of frequency, patients learn from: • The pharmacist, when the patient presents for a prescription held up for prior authorization • The prescriber's office, when the patient calls for a renewal and is told it cannot be processed • By the prescriber or staff at the time the prescription is written • By the insurance company, when the patient calls to make a complaint or get information about the prior authorization process The following is a suggested best practice: 1. If the prescriber is aware that prior authorization is required, there is a discussion with the patient during the visit. 2. The patient decides if they will pay for the prescription if the PA is denied	1. The need for prior authorization is flagged during prescribing in the system 2. The prescriber or support staff have a discussion with patient during the visit regarding the prior authorization 3. The patient decides if they will pay for the prescription if the ePA is denied

Rationale

The patient can be much more involved at the prescriber's office due to the ePA information arriving at the point of care. Coupled with the automatic population of information already contained in the electronic health record, the ePA can be completed quickly and efficiently. This limits the phone calls and follow-up required with the patient. The workflow is substantially changed, shifting the burden of patient education from the pharmacy to the prescriber and support staff, primarily because the discovery of the need for prior authorization is moved from the pharmacy during claims submission to the prescriber at the point of care.

Annotations and Comments



Today, health plans and Pharmacy Benefit Managers (PBMs) have a number of processes in place for providers to request prior authorizations. An electronic tool may be offered that is available 24/7 through a website to submit requests and get answers any time. The system prompts providers for the information needed to decide whether the request meets the proper criteria. If the request meets the criteria, approval will be sent immediately. If the request doesn't meet the criteria, it will be forwarded for review and a response will be given within 48 hours. Status of requests can be accessed online. There are also paper processes in place to request PAs, which are generally faxed to reviewers and responded to within 24 hours.

Advantages of electronic submission are editing for required fields, no handwriting interpretation, no longer needing to key information in and the ability to apply logic to simple requests. Industry standards for ePA are required to enable electronic prior authorization via eRx/EHR systems. This has been challenging in the past because all health plans and PBMs have different PA requirements and in order for ePA to work, there would need to be consensus on the requirements across the industry.

Assuming this was to occur, providers would be able to request PA directly from their eRx/EHR system and send the completed form electronically to the appropriate plan/PBM and/or authorization might be real-time based on a plan's logic and viewed via the eRx/EHR. Rural states still have massive high speed access limitations, so if ePA is required, technology issues remain.

The ideal ordering system is integrated with the PA process without leaving the application, not launching to another application. The ordering provider will be able to experience real-time prior authorization with the insurer, replacing the traditional phone or fax means of requesting prior authorization.

1. A formulary alert should display according to patient formulary and benefit plan (drug benefit)

If patient online access is available, entering an order for medication should also alert the patient of the PA process. The patient can initiate entry of information relevant to demographic and other necessary information to assist in the PA process. This would be part of renewal process of PA.

2. Provider should process electronic PA real time to support the following workflows:

    - ✓ The prescriber can proceed with the PA if the patient chooses to pay. When the real-time approved PA is received, the prescriber proceeds to transmit the eRX to the Pharmacy.
    - ✓ The prescriber can choose an alternative medication if the patient cannot pay, then proceeding to send the chosen alternative medication and transmit the eRX to the Pharmacy.
    - ✓ The prescriber can abandon the ePA without leaving the ordering application.

Having real-time PA with approval and transmitting the eRX to the pharmacy is expected to increase patient satisfaction, eliminating the waiting time for approval from payer and also the back and forth fax and phone exchange between the payer, pharmacy, and the prescriber's office.

ePA is expected to reduce administrative burden on providers who currently complete PA request forms, and on health plans that must review the request and send authorization. Patients would not have to wait for this process to occur in order to receive their prescription, which may have safety benefits through reducing the delays to therapy.

Foremost, some consideration should be given to the enormous changes facing the industry right now with 5010 and ICD-10, but standards and expectations must be identified and deadlines established well in advance to allow for all of the changes to be done. To help:

- Collaborate with payers with regards to standardization of the questions and answer used in PA fulfillment.
- Collaborate with software vendors on the best way integrate drugs with PA needs according to payer's formulary in real-time.

States with alerts language in statute – in context

SUMMARY

- FL, ND and NH address alerts as part of electronic prescribing laws
- ME and VT address alerts as part of regulating advertising of prescription drugs

Florida

CHAPTER 456 - HEALTH PROFESSIONS AND OCCUPATIONS: GENERAL PROVISIONS

456.42 Written prescriptions for medicinal drugs.—A written prescription for a medicinal drug issued by a health care practitioner licensed by law to prescribe such drug must be legibly printed or typed so as to be capable of being understood by the pharmacist filling the prescription; must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed, and the directions for use of the drug; must be dated; and must be signed by the prescribing practitioner on the day when issued. A written prescription for a controlled substance listed in chapter 893 must have the quantity of the drug prescribed in both textual and numerical formats and must be dated with the abbreviated month written out on the face of the prescription. However, a prescription that is electronically generated and transmitted must contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in numerical format, and the directions for use of the drug and must be dated and signed by the prescribing practitioner only on the day issued, which signature may be in an electronic format as defined in s. 668.003(4).
History.—s. 1, ch. 2003-41; s. 2, ch. 2006-271; s. 2, ch. 2009-202.

456.43 Electronic prescribing for medicinal drugs.—

(1) Electronic prescribing shall not interfere with a patient's freedom to choose a pharmacy.

(2) Electronic prescribing software shall not use any means or permit any other person to use any means, including, but not limited to, advertising, instant messaging, and pop-up ads, to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care. Such means shall not be triggered or in specific response to the input, selection, or act of a prescribing practitioner or his or her agent in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy.

(a) The term "prescribing decision" means a prescribing practitioner's decision to prescribe a certain pharmaceutical.

(b) The term "point of care" means the time that a prescribing practitioner or his or her agent is in the act of prescribing a certain pharmaceutical.

(3) Electronic prescribing software may show information regarding a payor's formulary as long as nothing is designed to preclude or make more difficult the act of a prescribing practitioner or patient selecting any particular pharmacy or pharmaceutical.
History.—s. 3, ch. 2006-271.

FL. Senate Bill 1408. Enacted; 2006.

New Hampshire

HB134 2007 - AN ACT relative to electronic prescribing for prescription drugs.

Be it Enacted by the Senate and House of Representatives in General Court convened:

320:1 Statement of Intent. The general court recognizes the benefit of new technologies in the area of health care. The general court recognizes the sanctity of confidential and secure health care information. The general court further recognizes the goal of the New Hampshire Citizen's Health Initiative to improve patient health and safety through electronic prescribing. The general court believes that the goal of electronic prescribing is best met through an environment that is confidential, secure, and free from commercial intrusion that may interfere with medical care and the patient-prescriber relationship. Therefore, the general court hereby establishes the framework to encourage electronic prescribing for the benefit of patients, prescribers, and payers of health care.

320:2 Prescriptions; Electronic Prescribing. Amend RSA 318:47-c to read as follows:
318:47-c Prescriptions.

I.(a) A prescription may be written, oral, or electronically transmitted. All oral prescriptions shall be immediately reduced to writing by the pharmacist or authorized technician receiving the oral prescription and shall indicate at least the name of the patient; the name, strength, and quantity of the drug prescribed; any directions specified by the prescriber; the name of the practitioner prescribing the medication; the date the prescription was ordered; a statement that the prescription was presented orally; and the name of the pharmacist who took the verbal order. The pharmacist who dispensed an original prescription shall indicate on the face of the prescription at least the assigned prescription identification number; the date of dispensing; the quantity actually dispensed; and his or her name or initials. The prescription shall be filed numerically by the assigned identification number for a period not less than 4 years. Such prescription files shall be open to inspection by the pharmacy board and its agents.

(b) A patient shall be entitled to receive a paper prescription instead of an oral or electronically transmitted prescription.

II.(a) A prescription that is electronically generated by a licensed prescriber, transmitted and received at the pharmacy by computer systems shall contain at least the name of the patient, the name, strength, and quantity of the drug prescribed, any directions specified by the prescriber, the name of the practitioner prescribing the medication, and shall be dated and signed by the prescribing practitioner on the day issued, and such signature shall be in an electronic format as defined in RSA 294-E:2, VIII.

(b) Electronic prescribing shall not interfere with a patient's freedom to choose a pharmacy.

(c) Electronic prescribing software *shall not use any means or permit any other person to use any means, including, but not limited to, advertising, instant messaging, and pop-up ads, to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care. Such means shall not be triggered by or in specific response to the input, selection, or act of a prescribing practitioner or his or her agent in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy.*

(d) Electronic prescribing software may show information regarding a payor's formulary, co-payment, or benefit plan as long as nothing is designed to preclude or make more difficult the act of a prescribing practitioner or patient selecting any particular pharmacy or pharmaceutical.

(e) No person who has access to electronic prescription information solely by transmitting or facilitating the transmission of prescriptions between the licensed prescriber generating the prescription and the pharmacy receiving the prescription, or any intermediary, shall retain the prescription or any information it contains for longer than is mandated by federal or state law, after which time the prescription information shall be destroyed. No such person shall sell, use, or otherwise make available the prescription information for any purpose other than transmission of prescriptions, prescription refills, and clinical information displayed to the prescriber or pharmacist.

320:3 Effective Date. This act shall take effect 60 days after its passage.

Approved: July 16, 2007
Effective: September 14, 2007

NH. House Bill 134. Enacted.; 2007.

North Dakota

CHAPTER 23-01 - ELECTRONIC DRUG PRIOR AUTHORIZATION AND TRANSMISSION - LIMITATIONS

1. Effective August 1, 2013, a drug prior authorization request must be accessible to a health care provider with the provider's electronic prescribing software system and must be accepted electronically, through a secure electronic transmission, by the payer, by the insurance company, or by the pharmacy benefit manager responsible for implementing or adjudicating or for implementing and adjudicating the authorization or denial of the prior authorization request. For purposes of this section, a facsimile is not an electronic transmission.

2. Effective August 1, 2013, electronic transmission devices used to communicate a prescription to a pharmacist may not use any means or permit any other person to use any means, including advertising, commercial messaging, and popup advertisements, to influence or attempt to influence through economic incentives the prescribing decision of a prescribing practitioner at the point of care. Such means may not be triggered by or be in specific response to the input, selection, or act of a prescribing practitioner or the prescribing practitioner's staff in prescribing a certain pharmaceutical or directing a patient to a certain pharmacy. Any electronic communication sent to the prescriber, including advertising, commercial messaging, or popup advertisements must be consistent with the product label, supported by scientific evidence and meet the federal food and drug administration requirements for advertising pharmaceutical products.

ND. House Bill 1422. Enacted; 2011.

Maine

Title 22: HEALTH AND WELFARE
Subtitle 2: HEALTH
Part 5: FOODS AND DRUGS
Chapter 605: PRESCRIPTION DRUG ADVERTISING HEADING: PL 2005, C. 392, §1 (NEW)

§2700-A. Prohibitions and required disclosures

1. Definitions. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

A. "Clinical trial" means a clinical investigation as defined by the federal Food and Drug Administration that involves any trial to test the safety or efficacy of a drug or biological product with one or more human subjects and that is intended to be submitted to, or held for inspection by, the federal Food and Drug Administration as part of an application for a research or marketing permit. [2005, c. 392, §1 (NEW).]

B. "Manufacturer of prescription drugs" or "manufacturer" means a manufacturer of prescription drugs or biological products or an affiliate of the manufacturer or a labeler that receives prescription drugs or biological products from a manufacturer or wholesaler and repackages those drugs or biological products for later retail sale and that has a labeler code from the federal Food and Drug Administration under 21 Code of Federal Regulations, 2027.20 (1999). [2005, c. 392, §1 (NEW).]

B-1. "Prescriber" means a person who is licensed, registered or otherwise authorized in the appropriate jurisdiction to prescribe and administer drugs in the course of professional practice. [2007, c. 362, §1 (NEW).]

C. "Regulated advertisement" means the presentation to the general public of a commercial message regarding a prescription drug or biological product by a manufacturer of prescription drugs that is:

(1) Broadcast on television or radio from a station that is physically located in the State;

(2) Broadcast over the Internet from a location in the State; or

(3) Printed in magazines or newspapers that are printed, distributed or sold in the State. [2005, c. 392, §1 (NEW).]

[2007, c. 362, §1 (AMD) .]

2. Regulated advertisement requirement. Beginning October 15, 2005, a manufacturer may not present or cause to be presented in the State a regulated advertisement, unless that advertisement meets the requirements concerning misbranded drugs and devices and prescription drug advertising of federal law and regulations under 21 United States Code, Sections 331 and 352(n) and 21 Code of Federal Regulations, Part 202 and state rules.

[2005, c. 392, §1 (NEW) .]

2-A. Software prohibition. *Beginning January 1, 2008, a person may not sell or distribute in the State computer software that influences or attempts to influence a prescribing decision of a prescriber to prescribe a certain drug or that directs a patient to a certain pharmacy. Features of computer software that are prohibited include, but are not limited to, pop-up and other advertisements, instant messages and economic incentives that are triggered by or in specific response to a selection, act or other input or designation of pharmacy by the prescriber or an agent of the prescriber. This subsection does not apply to in-house equipment provided within a hospital for use by prescribers and the hospital pharmacy or to information provided to a prescriber about prescription drug formulary compliance, patient care management or pharmacy reimbursement.*

[2007, c. 362, §2 (NEW) .]

3. Disclosure of clinical trials of prescription drugs. Beginning October 15, 2005, a manufacturer or labeler of prescription drugs that is required to report marketing costs for prescription drugs pursuant to section 2698-A shall post, with regard to those prescription drugs, on the publicly accessible Internet website of the federal National Institutes of Health or its successor agency or another publicly accessible website the following information concerning any clinical trial that the manufacturer conducted or sponsored on or after October 15, 2002:

A. The name of the entity that conducted or is conducting the clinical trial; [2005, c. 392, §1 (NEW).]
B. A summary of the purpose of the clinical trial; [2005, c. 392, §1 (NEW).]
C. The dates during which the trial has taken place; and [2005, c. 392, §1 (NEW).]
D. Information concerning the results of the clinical trial, including potential or actual adverse effects of the drug. [2005, c. 392, §1 (NEW).]
In order to satisfy the requirements of this subsection, the publicly accessible website and manner of posting must be acceptable to the department.
[2005, c. 392, §1 (NEW) .]
4. Fees. Beginning April 1, 2006, each manufacturer of prescription drugs that are provided to Maine residents through the MaineCare program under section 3174-G or the elderly low-cost drug program under section 254-D shall pay a fee of $1,000 per calendar year to the State. Fees collected under this subsection must be used to cover the cost of overseeing implementation of this section, including but not limited to maintaining links to publicly accessible websites to which manufacturers are posting clinical trial information under subsection 3 and other relevant sites, assessing whether and the extent to which Maine residents have been harmed by the use of a particular drug and undertaking the public education initiative under subsection 5 and the prescription drug academic detailing program under section 2685. One half of the annual revenues from this subsection must be allocated to and used for the academic detailing program under section 2685. Revenues received under this subsection, with the exception of funding designated for the academic detailing program under section 2685, must be deposited into an Other Special Revenue Funds account to be used for the purposes of this subsection.
[2007, c. 327, §2 (AMD) .]
5. Public education initiative. The department shall undertake a public education initiative to inform residents of the State about clinical trials and drug safety information and shall coordinate the public education program with the prescription drug academic detailing program under section 2685.
[2007, c. 327, §3 (AMD) .]
6. Penalties. A violation of this section is a violation of the Maine Unfair Trade Practices Act. Each day a manufacturer is in violation of this chapter is considered a separate violation.
[2005, c. 392, §1 (NEW) .]
7. Rulemaking. The department may adopt rules to implement this section. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.
[2005, c. 392, §1 (NEW) .]
SECTION HISTORY
2005, c. 392, §1 (NEW). 2005, c. 589, §2 (AMD). 2005, c. 683, §B17 (AMD). 2007, c. 327, §§2, 3 (AMD). 2007, c. 362, §§1, 2 (AMD).

ME. House Bill 1009. Enacted; 2007, c. 362, §2.

Vermont

TITLE 9 Commerce and Trade
PART 3 Sales, Assignments and Secured Transactions
CHAPTER 63. CONSUMER FRAUD
Subchapter 1. General Provisions

§ 2466a. Consumer protections; prescription drugs.
(a) A violation of 18 V.S.A. § 4631 shall be considered a prohibited practice under section 2453 of this title.
(b) As provided in 18 V.S.A. § 9473,, a violation of 18 V.S.A. § 9472 shall be considered a prohibited practice under section 2453 of this title.
(c) (1) It shall be a prohibited practice under section 2453 of this title for a manufacturer of prescription drugs to present or cause to be presented in the state a regulated advertisement if that advertisement does not comply with the requirements concerning drugs and devices and prescription drug advertising in federal law and regulations under 21 United States Code, Sections 331 and 352(n) and 21 Code of Federal Regulations, Part 202.
(2) For purposes of this section:
(A) "Manufacturer of prescription drugs" means a person authorized by law to manufacture, bottle, or pack drugs or biological products, a licensee or affiliate of that person, or a labeler that receives drugs or biological products from a manufacturer or wholesaler and repackages them for later retail sale and has a labeler code from the federal Food and Drug Administration under 21 Code of Federal Regulations, 2027.20 (1999).
(B) "Regulated advertisement" means:
(i) the presentation to the general public of a commercial message regarding a prescription drug or biological product by a manufacturer of prescription drugs that is broadcast on television, cable, or radio from a station or cable company that is physically located in the state, broadcast over the Internet from a location in the state, or printed in magazines or newspapers that are printed, distributed, or sold in the state; or
(ii) a commercial message regarding a prescription drug or biological product by a manufacturer of prescription drugs or its representative that is conveyed:
(I) to the office of a health care professional doing business in Vermont, including statements by representatives or employees of the manufacturer and materials mailed or delivered to the office; or
(II) at a conference or other professional meeting occurring in Vermont.
(d) No person shall sell, offer for sale, or distribute electronic prescribing software *that advertises, uses instant messaging and pop-up advertisements, or uses other means to influence or attempt to influence the prescribing decision of a health care professional through economic incentives or otherwise and which is triggered or in specific response to the input, selection, or act of a health care professional or agent in prescribing a specific prescription drug or directing a patient to a certain pharmacy. This subsection shall not apply to information provided to the health care professional about pharmacy reimbursement, prescription drug formulary compliance, and patient care management.*

Added 2007, No. 80, § 21; 2007, No. 89 (Adj. Sess.), § 5, eff. March 5, 2008.

VT. Senate Bill 115. Enacted; 2007.

States with electronic prior authorization language in statute – in context

SUMMARY

- MN and ND address the availability of standardized prior authorization forms and electronic access to the prior authorization process

Minnesota

62J.497 ELECTRONIC PRESCRIPTION DRUG PROGRAM.

Subd. 4. Development and use of uniform formulary exception form.

(a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.

(b) No later than January 1, 2011, the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions.

Subd. 5. Electronic drug prior authorization standardization and transmission.

(a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, 2015, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

History:
2008 c 358 art 4 s 3; 2009 c 79 art 4 s 3-6; 2009 c 102 s 3,4; 2009 c 173 art 1 s 1; 2010 c 336 s 4,5
Minnesota state code. §62J.497(5).

North Dakota

CHAPTER 23-01 - ELECTRONIC DRUG PRIOR AUTHORIZATION AND TRANSMISSION - LIMITATIONS

SECTION 2. ELECTRONIC DRUG PRIOR AUTHORIZATION STANDARDIZATION AND TRANSMISSION - REPORT TO LEGISLATIVE MANAGEMENT. During the 2011-12 interim, the health information technology advisory committee shall establish an outline on how best to standardize drug prior authorization request transactions between providers and the payers, insurance companies, and pharmacy benefit managers responsible for adjudicating the authorization or denial of the prescription request. The outline must be designed with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions and alignment with standards that are or will potentially be used nationally. By June 30, 2012, the health information technology advisory committee shall provide a report to the legislative management regarding the outline on how best to standardize drug prior authorization request transactions.

ND. House Bill 1422. Enacted; 2011.

Appendix F

SENATE BILL 117

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

John M. Sapien

AN ACT

RELATING TO DRUGS; PROVIDING FOR THE STANDARDIZATION OF ELECTRONIC PRIOR AUTHORIZATION OF PRESCRIPTIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. SHORT TITLE.--This act may be cited as the "Electronic Prior Authorization of Prescriptions Act".

SECTION 2. DEFINITION OF E-PRIOR AUTHORIZATION.--As used in the Electronic Prior Authorization of Prescriptions Act, "e-prior authorization" means a requirement that a prescriber obtain approval via electronic media from a health plan to prescribe a specific medication prior to dispensing.

SECTION 3. E-PRIOR AUTHORIZATION REQUEST TRANSACTION STANDARDIZATION.--On or before June 30, 2012, the board of pharmacy, in consultation with the insurance division of the public regulation commission, shall identify an outline on how best to standardize e-prior authorization request transactions between health care providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmission. The provisions of such e-prior

authorization request transactions standards shall, at a minimum, include:

A. health plans allowing for an e-prior authorization approval within forty-eight hours of a request;

B. allowing for dispensing a seventy-two-hour supply in an emergency;

C. prior authorization denials resulting in an explanation of benefit for patients similar to any other coverage denial, including communication of appeals rights at the time of denial;

D. coverage for prescription medications in all therapeutic classes and classes without e-prior authorization restrictions;

E. access without e-prior authorization provided to more than one drug or device per therapeutic class where more than one drug or device is available;

F. comprehensive review of all e-prior authorization access restrictions to be conducted at least annually;

G. coverage of new medications not included in the e-prior authorization restriction list until a determination is made as to whether the new medication shall be included in the e-prior authorization restriction list;

H. notification to each health care provider and pharmacy of any new e-prior authorization restrictions at least sixty days prior to the effective date of the restriction;

I. providing the e-prior authorization restriction list to any health care provider or a member of the public upon request; and

J. establishing a process to review grievances of health care providers and other interested parties concerning denial of e-prior authorization requests.

Appendix F

SECTION 4. ELECTRONIC DATA INTERCHANGE STANDARDS.--On or before January 1, 2015, the board of pharmacy, in consultation with the insurance division of the public regulation commission, shall develop standards by which health care providers and group purchasers will exchange standard e-prior authorization requests for drugs and devices using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

SECTION 5. ELECTRONIC PRIOR AUTHORIZATION REQUEST ACCESSIBILITY.--On or before January 1, 2016, e-prior authorization requests shall be accessible and submitted by providers, and accepted by group purchasers, through secure electronic transmissions. Facsimiles shall not be considered electronic submissions. Nothing in the Electronic Prior Authorization of Prescriptions Act shall preclude the option for paper e-prior authorization forms.

SECTION 6. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2011.

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing*

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Alabama	Pharmacy	Pharmacy law permits e-prescribing for noncontrolled drugs. E-prescribing is not defined, but appears to encompass computer-to-computer transmissions. Ala. Admin. Code r. 680-X-2-.32 (2008).	Pharmacy law does not permit e-prescribing for controlled substances until DEA issues regulations. Ala. Admin. Code r. 680-X-2-.32(1)(d) (2008).	Some of the pharmacy record-keeping requirements, particularly those that appear to require hard-copy printouts or bound log books, could be burdensome in an e-prescribing environment. See, e.g., Ala. Admin. Code r. 680-X-2-.15(c)(1), (h) (2008).
Alabama	Medical Doctors	—	Regulations governing medical doctors impede e-prescribing of controlled substances. They require prescriptions for Schedule II controlled substances to be written with ink or indelible pencil or typewriter and to be manually signed by the physician issuing the prescription. "Manually signed" means a nonelectronic, handwritten signature. Ala. Admin. Code r. 540-X-4-.05(1)(a), (2), (6) (2008).	—
Alabama	Medicaid	Regulations for prescribing noncontrolled outpatient drugs to Medicaid recipients facilitate e-prescribing. Distinguish between "written" prescriptions, which must be on tamper-resistant prescription pads, and e-prescriptions, which are expressly exempt from provision. Ala. Admin. Code r. 560-X-16-.01(7)(a) (2008).	Regulations require signatures on prescriptions for Schedule II controlled substances. Stamped or typewritten signatures are not acceptable. Ala. Admin. Code r. 560-X-16-.01 (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Alabama	Food & Drug	—	Schedule II controlled substances require a written prescription unless very limited exceptions apply (e.g., emergency or for resident of long-term care facility). Ala. Code § 20-2-58 (2008).	—
Alaska	Pharmacy	Pharmacy regulations permit prescriptions for both legend drugs and controlled substances to be transmitted electronically, where permitted under state and federal law. Alaska Admin. Code tit. 12, § 52.490 (2009).	Pharmacy regulations permit prescriptions for both legend drugs and controlled substances to be transmitted electronically, where permitted under state and federal law. Alaska Admin. Code tit. 12, § 52.490 (2009).	Pharmacy record-keeping requirements are somewhat ambiguous. Require pharmacy to maintain "plain paper version" of electronically transmitted prescription drug orders, but also permit pharmacy to maintain a prescription drug order "put into writing either manually or electronically by the pharmacist." Alaska Admin. Code tit. 12, § 52.450 (2009).
Alaska	Medicaid	The AK Medicaid regulation permits electronic transmissions that are in accordance with the pharmacy regulation (Alaska Admin. Code tit. 12, § 52.490), which permits electronic transmission of prescriptions for legend and controlled substances in accordance with federal law. Alaska Admin. Code tit. 7, § 43.591(r) (2009).	The AK Medicaid regulation permits electronic transmissions that are in accordance with the pharmacy regulation (Alaska Admin. Code tit. 12, § 52.490), which permits electronic transmission of prescriptions for legend and controlled substances in accordance with federal law. Alaska Admin. Code tit. 7, § 43.591(r) (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Arizona	Pharmacy	Pharmacy statute and regulations permit e-prescribing. Ariz. Rev. Stat. Ann. § 32-1968(A) (2008); Ariz. Admin. Code § R4-23-407(A)(1)(j) and (F) (2008).	Pharmacy regulations require compliance with federal law for electronic transmission of Schedule II, III, IV, or V controlled substance prescription orders. Ariz. Admin. Code § R4-23-407(A)(h), (F)(2) (2008).	Pharmacy statute and regulations facilitate e-prescribing. Regulations provide that a pharmacist does not have to create a hard-copy prescription if the pharmacy's computer system fields are automatically populated by an electronically transmitted prescription order and the computer system is capable of maintaining, printing, and providing all the prescription information required by statute within 72 hours of a request by authorized entities and persons. Ariz. Rev. Stat. Ann. § 32-1964(B) (2008); Ariz. Admin. Code § R4-23-408(C)(4), (H)(2) (2008).
Arizona	Medical Doctors	Statute regarding homeopathic physicians appears to address only written prescriptions. Ariz. Rev. Stat. Ann. § 32-2951(C) (2008).	Statute regarding homeopathic physicians appears to address only written prescriptions. Ariz. Rev. Stat. Ann. § 32-2951(C) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Arizona	Public Health and Safety—Uniform Controlled Substances Act	—	The AZ Uniform Controlled Substances Act specifically requires a written, manually signed prescription for Schedule II controlled substances in most circumstances. Authorizes only written or oral prescriptions for other controlled substances. Appears that "written" does not include e-prescribing, given that the term is not treated as encompassing e-prescriptions in the regulations. Ariz. Rev. Stat. Ann. § 36-2525(A), (D), (H), (I) (2008).	—
Arkansas	Pharmacy	Pharmacy regulations permit e-prescribing (at least where the pharmacist reduces the e-prescription to different "form"), but this appears to be limited to noncontrolled substances. 070-00-007 Ark. Code R. § 0008(c) (2009); 070-00-007 Ark. Code R. § 0008(a)(2) (2009).	Regulations permit Schedule III, IV, or V controlled substances or legend drugs to be prescribed only pursuant to either a written prescription signed by a prescribing individual practitioner or a facsimile of a written signed prescription transmitted directly by the prescribing practitioner, or orally if reduced to writing by the pharmacist. 070-00-007 Ark. Code R. § 07-00-0001(c)(1) (2009).	—
Arkansas	Medicaid	—	—	The AR Medicaid regulations seem to imply that a written prescription is required for Medicaid-covered pharmacy services. 016-06-035 Ark. Code R. § 221.000(C), (D) (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Arkansas	Food & Drug/ Uniform Narcotic Drug Act	—	AR Food & Drug law/Uniform Narcotic Drug Act requires a written, manually signed prescription for narcotic drugs or controlled substances. Ark. Code Ann. § 20-64-206(1) (2008); 007-07-009 Ark. Code R. § 8(B)(c), 8(G)(a) (2009).	—
Arkansas	Criminal Offenses/ Controlled Substances	—	AR Criminal Offenses/ Controlled Substances law requires a written prescription for Schedule II controlled substances. Ark. Code Ann. § 5-64-308 (2008).	Records of Schedule I and II substances must be maintained separately from all other records. 007-07-009 Ark. Code R. § 6(E) (2009).
California	Pharmacy	CA Pharmacy law permits e-prescribing for noncontrolled substances (controlled substances are addressed by the CA Health and Safety Code). Cal. Bus. & Prof. Code § 4071.1(a) (2008); Cal. Bus. & Prof. Code § 4040(a)(1) (2008).	—	A pharmacy is permitted to maintain the e-prescription in electronic form provided that it can retrieve the prescription in hard copy for a 3-year period from the date of last dispensing. Cal. Bus. & Prof. Code § 4070(b) (2008).
California	Medicaid	CA Medicaid regulations permit e-prescribing and expressly recognize validity of e-signatures that meet the conditions of the Electronic Signature in Global and National Commerce Act (15 U.S.C. Sec. 7001). Cal. Welf. & Inst. Code § 14170.10(a), (b) (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
California	Health and Safety Code/Uniform Controlled Substances Act	—	CA's Health and Safety Code permits e-prescribing for controlled substances with the approval of the CA State Board of Pharmacy and the Department of Justice if the e-prescribing is authorized by federal law and in accordance with regulations promulgated by the Drug Enforcement Administration. Cal. Health & Safety Code § 11164 (2008); Cal. Health & Safety Code § 11164.5 (2008).	CA's Health and Safety Code generally requires that a prescription for a Schedule II controlled substance be on a special form, signed by the prescriber in ink. Prescriptions for controlled substances in Schedules III–V may be orally or electronically transmitted, but they must subsequently be produced in a hard-copy form that is signed by the pharmacist filling the prescription. The law specifically makes an exception for the foregoing requirements if the Board of Pharmacy and Justice Dept. approve electronic transmission for such prescriptions and the prescription complies with applicable DEA regulations. Cal. Health & Safety Code § 11164.5 (2008).
Colorado	Pharmacy	CO Pharmacy law permits prescription orders to be "transmitted electronically" (distinct from transmission by fax), but does not define this term or provide instructions for e-prescribing. Colo. Rev. Stat. § 12-22-122(1)(2008); Colo. Rev. Stat. § 12-22-102(22.5)(a) (2008); 3 Colo. Code. Regs. § 719-1(2.00.10)(b) (2009).	—	Record-keeping requirements may be met with an electronic record-keeping system capable of producing hard copies upon request. 3 Colo. Code Regs. § 719-1(11.04.10), (11.04.30) (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Colorado	Medicaid	CO Medicaid regulations permit e-prescribing, but appear to require that pharmacists reduce e-prescriptions to hard copy for retention purposes. 10 Colo. Code Regs. § 2505-10 (8.837.1.A, 8.837.2.C, 8.837.3.A) (2009).	—	—
Colorado	Criminal Code/Uniform Controlled Substances Act of 1992	—	CO's Uniform Controlled Substances Act requires written prescriptions for Schedule II controlled substances, but permits "electronically transmitted" prescriptions for Schedule III–V controlled substances. Colo. Rev. Stat. § 18-18-308(3) (2008); Colo. Rev. Stat. § 18-18-414(1)(c), (2) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Connecticut	Pharmacy	CT Pharmacy/Pharmacist law may impede e-prescribing. Although the law permits a prescription to be transmitted to a pharmacy in an "electronic manner," and the law contemplates computer-to-computer transmissions, record-keeping requirements may be burdensome. A pharmacist who receives an electronically transmitted prescription must promptly record it on either a prescription form or a computerized printed record, assign it a serial number, and file it in numerical order. [Note: Connecticut SHB 6301, which was voted out of committee on 2/19/09, would change record-keeping requirements of pharmacies to allow for electronic files.] Conn. Gen. Stat. § 20-614 (2008); Conn. Gen. Stat. § 20-615 (2008).	—	An "electronic data intermediary" (i.e., an entity that provides the infrastructure that electronically connects practitioner and pharmacy systems or devices to facilitate secure e-prescribing) must obtain approval of CT Commissioner of Consumer Protection before operating in state. Conn. Gen. Stat. § 20-614 (2008).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Connecticut	Consumer Protection	—	Consumer Protection law may impede e-prescribing. Although it permits electronically transmitted prescriptions for Schedule III and IV controlled substances to the extent allowed by federal law, it requires that a pharmacist reduce the e-prescription orders to writing or print them out and then file them in consecutive order, with Schedule II prescriptions in a separate file. Conn. Gen. Stat. § 21a-249(c)-(f), (h), (k) (2008).	—
Connecticut	Public Health and Well-Being	CT Public Health law provides general authorization for e-prescribing. In addition, by Nov. 30, 2007, the Department of Public Health, within available appropriations, was to have contracted for a health information technology plan intended to facilitate the development of a statewide electronic health information system encompassing e-prescribing. Conn. Gen. Stat. § 19a-25b (2008); Conn. Gen. Stat. § 19a-25d(a)(1), (b) (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Delaware	Pharmacy	DE Pharmacy law permits e-prescribing for noncontrolled substances, but not for controlled substances. Del. Code Ann. tit. 24, § 2523(7) (2009); 24-2500 Del. Code. Regs. § 5.10 (.1-.6) (2009).	Prescription orders for controlled substances must be hand-signed by the practitioner. 24-2500 Del. Code Regs. §§ 5.10.6, 5.10.7.5 (2009).	Pharmacy regulation permits electronic maintenance of prescriptions. Requires a daily hard-copy printout of electronic prescriptions or a log book which must be manually signed by the dispenser. 24-2500 Del. Code Regs. § 5.2.3 (2009).
Delaware	Medical Doctors	Statute requires basic information on prescription (e.g., name and strength of drug prescribed) to be clearly written, clearly hand printed, electronically printed, or typed. Del. Code Ann. tit. 24, § 1764A (2009).	—	—
Delaware	Medicaid	Medicaid regulations recognize electronic prescribing. 40-850-001 Del. Code Regs. § 1.6.1 (2009); accord 40-850-027 Del. Code Regs. § 1.11.1.5 (2009); 40-850-026 Del. Code Regs. § 2.1.2 (2009).	—	The Medicaid regulation requiring that prescribers note ICD-9 codes in their own handwriting on prescriptions for STD drugs is inconsistent with e-prescribing. 40-850-001 Del. Code Regs. § 1.22.2.2.3 (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Delaware	Food & Drug/ Controlled Substances Act	—	DE Food and Drug law/ Controlled Substance Act and the accompanying regulations do not appear to contemplate e-prescribing, although faxed prescriptions are permitted in certain circumstances. A practitioner is required to manually sign a prescription for a controlled substance in the same manner as he or she would sign a check or legal document. When an oral order is not permitted, prescriptions must be written with ink or indelible pencil or typewriter and be manually signed by the practitioner. Del. Code Ann. tit. 16, § 4739 (2009); 16-4000-4426 Del. Code Regs. §§ 4.2.3, 4.4 D (2009).	The record-keeping requirements for dispensed controlled substances (e.g., a log book at least 8 by 11 inches in dimension) are inconsistent with e-prescribing. 16-4000-4426 Del. Code Regs. § 3.1 (2009).
District of Columbia	Pharmacy	The DC Health Occupations Boards statutory provisions do not appear to address e-prescriptions. D.C. Code Ann. § 3-1201.02(11)(B)(ii) (2009).	—	—
District of Columbia	Medicaid	DC Medicaid regulation exempts e-prescription orders from the tamper-resistant prescription pad requirements applicable to written prescriptions for Medicaid recipients. D.C. Mun. Regs. tit. 22, § 1333.4 (2009).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
District of Columbia	Food & Drug	DC Food & Drug law requires a written prescription for Schedule II substances and a written or oral prescription for Schedule III or IV substances. "Written prescription" is not defined. D.C. Code Ann. § 48-903.08 (2009).	—	—
District of Columbia	Public Health and Medicine	Public Health and Medicine regulations contain detailed standards for e-prescribing in DC. They permit e-prescribing for noncontrolled substances and specify content; nonetheless, they appear to impede e-prescribing by requiring that the electronic transmission be "immediately reduced to hard copy and filed." D.C. Mun. Regs. tit. 22, § 1300.2 (2009); D.C Mun. Regs. tit. 22, § 1304 (2009).	DC Public Health and Medicine regulations generally require • a manually signed, written prescription for Schedule II controlled substances; and • a written, faxed, or oral prescription (immediately reduced to writing by the pharmacist) for Schedule III–V substances. However, regulations make an exception where "otherwise permitted by federal law," effectively allowing e-prescribing to extent permitted by federal law. D.C. Mun. Regs. tit. 22, §§ 1306.1, 1306.4, 1306.5 (2009); D.C. Mun. Regs. tit. 22, § 1309 (2009); D.C. Mun. Regs. tit. 22, § 1301.2 (2009); accord D.C. Mun. Regs. tit. 22, § 1303.7(c) (2009).	Permits electronic record keeping for controlled substance prescriptions so long as original documents are retrievable by prescriber's name, patient's name, drug dispensed, and date filled. D.C. Mun. Regs. tit. 22, § 1313 (2009) D.C. Mun. Regs. tit. 22, § 1913.9 (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Florida	Pharmacy	FL Pharmacy law permits e-prescribing, but does not define the term. Fla. Stat. Ann. § 456.42 (2009).	—	Regulation requires approval of the patient (or patient's agent) for any direct transmission of prescriptions, including electronic data transmission. Fla. Admin. Code Ann. r. 64B16-27.1003 (2009). Statute prohibits electronic prescribing software from using any means including advertising, instant messaging, and pop-up ads, to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision of a prescribing practitioner at the point of care. Fla. Stat. Ann. § 456.43(2) (2009).
Florida	Medicaid	FL Medicaid regulations define "prescription" as encompassing orders for drugs "transmitted by any means of communication." This broad definition appears to cover e-prescriptions. Fla. Admin. Code Ann. r. 59G-1.010(223) (2009).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Florida	Public Health	—	—	The FL legislature has sought to promote the implementation of e-prescribing by establishing a clearinghouse to make information on e-prescribing available. The state Agency for Health Care Administration is to provide yearly reports on the progress of implementing e-prescribing. Fla. Stat. Ann. § 408.0611 (2009).
Florida	Crimes	—	FL "Crimes" law permits oral prescriptions for Schedule III and IV substances if the pharmacist reduces the prescription to writing or records it electronically (federal law permitting) before filling it. Law addresses written and oral prescriptions, and pharmacist electronically recording prescription, but does not address prescriber electronically transmitting prescription for controlled substances. Fla. Stat. Ann. § 893.04 (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Georgia	Pharmacy	GA Pharmacy regulations permit e-prescribing for noncontrolled substances. Establishes basic content requirements (e.g., name, address, and phone number of prescriber; date and time of transmission) and provides that e-prescriptions which meet state requirements are official prescriptions. Regulations have separate standards for prescriptions sent by e-mail, which must be encrypted, accompanied by a digital ID, and reduced to hard copy and maintained by the pharmacist. Pharmacist has obligation to ensure accuracy and authenticity of e-prescriptions, but in the absence of unusual circumstances may presume those sent from an intervening electronic formatter are accurate and authentic. GA. Comp. R. & Regs. 480-27-.02 (2009); GA. Comp. R. & Regs. 480-27-.04 (2009); GA. Comp. R. & Regs. 480-27-.01 (2009).	Electronically transmitted prescriptions may not be for controlled substances except as may be allowed by federal law. GA. Comp. R. & Regs. 480-27-.02(2) (2009). GA regulations require manually signed, written prescriptions for Schedule II controlled substances. Moreover, a pharmacist must manually sign his or her name to a written prescription for a Schedule II controlled substance when he or she dispenses the drug. Although the regulations appear to permit electronically transmitted prescriptions for Schedule III–V controlled substances, the pharmacist is required to reduce the e-prescription to a hard copy. GA. Comp. R. & Regs. 480-22-.03(1) (2009); GA. Comp. R. & Regs. 480-22-.04 (2009); GA. Comp. R. & Regs. 480-22-.07 (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Georgia	Food & Drug	GA Food & Drug law generally permits e-prescribing, but defers to the state Board of Pharmacy and the federal DEA to decide the acceptable means for transmitting a prescription for a Schedule II controlled substance. Ga. Code Ann. § 26-4-80 (2008).	GA Food & Drug law requires that Schedule II controlled substance prescriptions in written form be signed in indelible ink by the practitioner. However, other forms of Schedule II controlled substance prescription drug orders may be accepted and dispensed in accordance with regulations promulgated by the board and in accordance with DEA regulations found in 21 C.F.R. 1306. Ga. Code Ann. § 26-4-80 (2008).	—
Georgia	Crimes and Offenses/ Controlled Substances	—	In nonemergency situations, GA Controlled Substances law requires a written prescription for a Schedule II controlled substance unless state regulations or federal DEA regulations permit a prescription that is transmitted via fax or "other electronic means." Prescriptions for Schedule III–V controlled substances require a written or oral prescription. Ga. Code Ann. § 16-13-41 (2008).	—
Guam	Pharmacy	Guam Pharmacy regulations do not appear to contemplate e-prescribing. They describe the prescriptions a pharmacist receives as "oral or written." 25 Guam Admin. R. & Regs. § 13108(a)(1)(i) (1997).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Guam	Food & Drug	—	Guam Food, Drug, and Cosmetic Act does not expressly recognize e-prescribing, only written and oral prescriptions. Guam Code Ann. tit. 10, § 40116(a) (2008).	—
Guam	Crimes and Corrections/Guam Uniform Controlled Substances Act	—	The Guam Uniform Controlled Substances Act requires written prescriptions for Schedule II controlled substances and written or oral prescriptions for other controlled substances. Guam Code Ann. tit. 9, § 67.308.1(c)-(e) (2008).	—
Hawaii	Pharmacy	HI Pharmacy regulations do not address e-prescribing. Prescriptions may be written, faxed, or telephoned, but telephoned prescriptions must be reduced to writing by the pharmacist. Haw. Code R. § 16-95-2 (2009); Haw. Code R. § 16-95-82 (2009).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Hawaii	Food & Drug	HI Food & Drug law permits "electronic prescriptions," defined to include both fax and other e-prescriptions. Out-of-state e-prescriptions are expressly permitted. E-prescriptions must be irrefutably traceable to the prescribing practitioner by a recognizable and unique practitioner identifier, including electronic and digital signatures. Pharmacist must maintain records that identify the format (oral, written, or electronic) in which the prescription was received. Haw. Rev. Stat. Ann. §§ 328-16(c)(1), 328-17.6(a) 328-17.7(a)(9), 328-17.8 (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Hawaii	Health/Uniform Controlled Substances Act	—	HI's Uniform Controlled Substances Act does not appear to contemplate e-prescriptions: • Prescriptions for all controlled substances must originate within the state. • Schedule II controlled substances must be written and manually signed (except in emergency situations). • Prescriptions for controlled substances in Schedule III, IV, or V may be written, a facsimile of a written prescription, or oral (if the oral prescription is reduced to writing by the pharmacist). Haw. Rev. Stat. Ann. § 329-8(a), (e), (g), (j) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Hawaii	Department of Public Safety/Law Enforcement/ Regulation of Controlled Substances	—	The HI Department of Public Safety regulations for controlled substances do not encompass e-prescribing: • Schedule II controlled substance prescriptions must be in writing (except in an emergency situation) on forms of a specified size and submitted in duplicate. • The pharmacist must manually endorse the prescription. Emergency dispensing of controlled substances must be in accordance with section 1306-11(d), Title 21 Code of Federal Regulations. • Oral prescriptions for Schedule III–V controlled substances must be reduced to a written memorandum by the pharmacist which he or she then manually endorses. • Pharmacies which maintain electronic records of controlled prescriptions must provide a daily printout of those prescriptions. Haw. Code R. § 23-200-15(a), (c)-(e), (h) (2009); Haw. Code R. § 23-200-16(a), (b) (2009); Haw. Code R. § 23-200-18 (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Idaho	Pharmacy	ID Pharmacy law permits prescription drug orders to be sent electronically pursuant to ID's Uniform Electronic Transactions Act, which provides that a law that requires a record to be in writing is satisfied by an electronic record and that a law that requires a signature is satisfied by an electronic signature. Idaho Code Ann. § 54-1733(c) (2008); Idaho Code Ann. § 28-50-107(c), (d) (2008).	ID Pharmacy regulations require that prescriptions for controlled substances be in writing, although prescriptions for Schedule III or IV controlled substances may be oral if the prescription is promptly reduced to writing by the pharmacist. Idaho Admin. Code r. 27.01.01.442 (.01) (2007); Idaho Admin. Code r. 27.01.01.446 (.01) (2007).	—
Idaho	Food & Drug	—	Schedule II controlled substances require a manually signed written prescription (except in an emergency situation). Schedule III and IV prescriptions require a written or oral prescription. Idaho Code Ann. § 37-2722 (2008); Idaho Code Ann. § 37-2723 (2008); Idaho Code Ann. § 37-2725(1), (6) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Illinois	Pharmacy	IL Pharmacy law permits electronically transmitted prescriptions, distinct from facsimile prescriptions, but provides no instructions for e-prescriptions. Pharmacy Practice Act also permits maintaining prescriptions electronically as original records so long as computer system can capture an unalterable electronic visual image and is capable of printing and providing required prescription information to the department within 72 hours of request. 225 Ill. Comp. Stat. Ann. 85/3(e), (z) (2009); 225 Ill. Comp. Stat. Ann. 85/25.20 (2009).	—	—
Illinois	Medicaid	—	—	IL Medicaid regulations suggest that manually signed, written prescriptions may be required in the Medicaid program. They specifically require the physician's "legible signature in ink." Ill. Admin. Code tit. 89, § 140.414(a) (2009); accord Ill. Admin. Code tit. 89, § 140.443(a) (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Illinois	Food & Drug	—	—	IL Food, Drug and Cosmetic Act defines "prescription" to include only written, faxed, or verbal orders. It is unclear whether "written" includes an electronically transmitted prescription. 410 Ill. Comp. Stat. Ann. 620/2.36 (2009).
Illinois	Criminal Offenses/ Illinois Controlled Substances Act	—	IL's Criminal Offenses law does not address e-prescribing. It requires a written prescription for a Schedule II controlled substance (except in an emergency situation) and a written, faxed, or oral prescription (reduced to writing by the pharmacist) for Schedule III–V controlled substances. The pharmacist must sign his or her own name to the face of a written prescription or on the memorandum he or she generates for an oral prescription. 720 Ill. Comp. Stat. Ann. 570/309 (2009); 720 Ill. Comp. Stat. Ann. 570/312 (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Illinois	Public Health/ Department of Alcoholism and Substance Abuse/ Controlled Substances Activities	The IL Public Health regulations include definitions of "electronic device" and "prescribed" that suggest that e-prescribing is permitted, yet e-prescribing does not appear to be substantively addressed elsewhere in that regulatory part. Ill. Admin. Code tit. 77, § 2080.20 (2009).	Regulations of the IL Department of Alcoholism and Substance Abuse permit written, faxed, or verbal prescriptions for Schedule II drugs. Presumably, the verbal prescriptions are permitted only in emergency situations. E-prescribing is not addressed. Ill. Admin. Code tit. 77, § 2080.70 (2009).	—
Illinois	Public Health/ Department of Professional Regulation/Illinois Controlled Substances Act	—	The regulations of IL's Department of Professional Regulation are not compatible with e-prescribing. They prohibit a pharmacist from filling a prescription for a Schedule II controlled substance that is not on a triplicate prescription blank (out-of-state and PHS prescribers may use a conventional prescription form), except in an emergency situation. Moreover, prescribers must manually sign a prescription for a controlled substance. Ill. Admin. Code tit. 77, § 3100.390(a) (2009); Ill. Admin. Code tit. 77, § 3100.400(a), (d) (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Indiana	Pharmacy	IN Pharmacy law permits e-prescribing provided that the prescription information is transmitted by an electronic data intermediary approved by the IN Board of Pharmacy. Electronic prescriptions transmitted through e-mail without the use of an electronic data intermediary are prohibited. Ind. Code Ann. § 25-26-13-25(b) (2008); Ind. Code Ann. § 25-26-13-25.5 (2008); 856 Ind. Admin. Code 1-40-10 (2008).	IN Pharmacy regulations require a written, manually signed prescription for a Schedule II controlled substance except in an emergency situation. Schedule III or IV controlled substances may be written, faxed, or prescribed orally if the pharmacist promptly reduces the prescription to writing. 856 Ind. Admin. Code 2-6-4(a) (2008); 856 Ind. Admin. Code 2-6-7(a) (2008); 856 Ind. Admin. Code 2-6-12(a) (2008); 856 Ind. Admin. Code 1-31-2(4), (8) (2008).	—
Indiana	Medical Doctors	The IN Medical Licensing Board regulations address the appropriate use of the Internet in medical practice. They state that patients must provide signed, informed consent to electronic transmissions, including e-prescriptions, and that physicians must maintain written policies for electronic transmissions. E-prescriptions must be secure within existing technology. 844 Ind. Admin. Code 5-3-4 (2008); 844 Ind. Admin. Code 5-3-5 (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Indiana	Food & Drug	IN Food & Drug law permits e-prescriptions for drugs to the extent permitted by federal law. Ind. Code Ann. § 16-42-3-6(b), (i) (2008); Ind. Code Ann. § 16-42-19.7 (2008).	Drugs that have been designated habit forming by the state as well as by regulations issued under 21 USC 352(d) may be dispensed upon an electronically transmitted prescription only to the extent permitted by federal law. Ind. Code Ann. § 16-42-3-6(b), (i) (2008).	—
Indiana	Criminal Law and Procedure	—	IN Criminal law does not address e-prescribing. It requires a written prescription for Schedule II substances unless an exception applies. Schedule III or IV controlled substances require a written, oral, or faxed prescription. Ind. Code Ann. § 35-48-3-9 (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Iowa	Pharmacy	IA Pharmacy law is intended to facilitate e-prescribing. It permits e-prescriptions (defined to include both computer-to-computer and fax prescriptions) for noncontrolled substances. The law also requires electronic signatures and requires verification of authenticity of prescriptions. It permits verification through a number of different means, including maintaining a practitioner number reference, electronic signature file, or verifying via telephone. Iowa Code Ann. § 155A.27 (1), (2) (2008); Iowa Code Ann. § 155A.3 (16), (17), (38) (2008); Iowa Admin. Code r. 657-21.1 (2008); Iowa Admin. Code r. 657-21.3 (2008).	IA Pharmacy/Pharmacist regulations require a manually signed, written prescription for Schedule II controlled substances. An electronically transmitted prescription is allowed in an emergency situation, but the pharmacist must prepare a temporary written record of the prescription (such as a hard copy of the electronic transmission). The prescriber must deliver, in person or via mail, a written prescription within 7 days to the pharmacist. Iowa Admin. Code r. 657-10.21 (2008); Iowa Admin. Code r. 657-10.22(2) (2008). For controlled substances other than Schedule II substances, a faxed prescription is permissible. Iowa Admin. Code r. 657-21.9 (2008). In contrast to these Pharmacy regulations, IA Public Health law relating to controlled substances permits e-prescriptions for controlled substances (including Schedule II controlled substances) if permitted by federal law (see below).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Iowa	Medical Doctors	IA Public Health law covering "Health-Related Professions" provides that a physician who dispenses prescription drugs must offer to transmit a patient's prescription electronically (complying with pharmacy law prescription requirements) to a pharmacy of the patient's choice. Iowa Code Ann. § 147.107 (2008).	—	—
Iowa	Medicaid	IA Medicaid law adopts the prescription requirements of IA Public Health/Controlled Substances law and applies them to all prescriptions. (The Public Health/Controlled Substances law permits e-prescriptions [even for Schedule II controlled substances] if permitted by federal law [see below]). Iowa Admin. Code r. 441-78.2(2) (2008).	IA Medicaid law adopts the prescription requirements of IA Public Health/Controlled Substances law and applies them to all prescriptions. (The Public Health/Controlled Substances law permits e-prescriptions [even for Schedule II controlled substances] if permitted by federal law [see below]). Iowa Admin. Code r. 441-78.2(2) (2008).	—
Iowa	Food & Drug	IA Food & Drug law permits e-prescriptions (which are distinct from facsimile prescriptions), which comply with Iowa Code 155A.27, the pharmacy code provision that sets out the requirements for prescriptions. Iowa Code Ann. § 126.11(3)(a), (3)(f) (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Iowa	Public Health/ Alcoholic Beverages and Controlled Substances	—	IA Public Health law relating to controlled substances permits e-prescriptions for controlled substances (including Schedule II controlled substances) if permitted by federal law. Iowa Code Ann. § 124.308 (2008). This contrasts with IA Pharmacy regulations which require a manually signed, written prescription for Schedule II substances and permit faxed prescriptions (but apparently not computer-to-computer prescriptions) for other controlled substances (see above).	—
Kansas	Pharmacy	KS Pharmacy law expressly permits e-prescriptions for noncontrolled substances that are distinct from faxed prescriptions. (The statutory definition of "electronic transmission" includes the transmission of information in "electronic form" as well as the transmission of an "exact visual image of a document" [i.e., a fax]). However, the law requires that the pharmacist maintain the e-prescription in hard-copy form, which appears to impede e-prescribing. Kan. Stat. Ann. § 65-1637 (2007); Kan. Stat. Ann. § 65-1626(d), (s), (ll) (2007); Kan. Admin. Regs. § 68-2-22 (2008).	Prescriptions for Schedule II controlled substances must be written and manually signed except for emergencies and other limited situations. Law permits electronic transmission of Schedule II prescriptions in an emergency, but hard copy must be presented to the pharmacist within 7 days. E-prescriptions for controlled substances in Schedules III–V are allowable if the pharmacist immediately reduces the drug order to a hard copy. Kan. Admin. Regs. § 68-20-10a (2008); Kan. Admin. Regs. § 68-20-18 (2008); Kan. Admin. Regs. § 68-20-19(a)(1) (2008); Kan. Admin. Regs. § 68-20-20(a)(1) (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Kansas	Food & Drug	—	KS Food, Drug and Cosmetics Code appears to impede e-prescribing. Does not expressly recognize e-prescribing (unlike Pharmacy Code) and requires "written prescription" or "oral prescription" which is reduced to writing by pharmacist. Kan. Stat. Ann. § 65-669(q) (2007).	—
Kansas	Public Health/ Controlled Substances	—	KS Controlled Substance law requires a written prescription for Schedule II substances, although an oral prescription is permissible in an emergency. Schedule III and IV substances require a written or oral prescription. The statute does not address e-prescribing. Kan. Stat. Ann. § 65-4123 (2007).	—
Kentucky	Pharmacy	—	—	KY Pharmacy law does not address e-prescribing. However, the regulation regarding computerized record keeping includes a requirement that would be incompatible with a paper-free system: a daily hard-copy printout or log book of prescription data which must be signed by the filling pharmacist. 201 KY. Admin. Regs. 2:170 § 1 (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Kentucky	Public Health/ Controlled Substances	—	KY Public Health/Controlled Substances law generally requires a manually signed, written prescription for Schedule II controlled substances. Regulations permit transmittal of Schedule II prescriptions in limited circumstances (e.g., direct administration to a patient) via facsimile only. Prescriptions for Schedule III–V substances may be prescribed in writing (using a security prescription blank), electronically, or orally. E-prescriptions must be reduced to writing by the pharmacist. Regulations expressly state that a prescription contained in a computer or other electronic format is not to be considered "writing." KY. Rev. Stat. Ann. § 218A.180 (1), (2), (4), (5), (6) (2009); 902 KY Admin. Regs. 55:095 § 2 (2009).	—
Louisiana	Pharmacy	The impact of LA Pharmacy law on e-prescribing is unclear. Pharmacy law permits e-prescriptions, but it appears the term may be limited to electronic transmission of the exact visual image (refers to "prescription form" and requires prescriber to indicate in a "check box" for DAW). LA. Admin. Code tit. 46, § LIII.2511(A), (D) (2008).	LA Pharmacy law permits e-prescriptions for Schedule III–V controlled substances, but a handwritten signature is required on prescriptions for Schedule II controlled substances. Permits facsimile to serve as original written prescription for Schedule II controlled substances in limited circumstances (e.g., prescription for long-term care resident). LA. Admin. Code tit. 46, § LIII.2543(A)-(C) (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Louisiana	Medical Doctors	LA Medical Doctor regulations permit physicians and physician assistants to transmit prescriptions electronically. LA. Admin. Code tit. 46, § XLV:7403(A) (2008); LA. Admin. Code tit. 46, § XLV.4505(D) (2008); accord LA. Admin. Code tit. 46, § XLV.4506(A.1)(b) (2008). (But impact of physician/ physician assistant laws unclear. Require prescriber to check a box labeled "Dispense as Written" or "DAW" to prevent generic substitution. LA. Admin. Code tit. 46, XLV § 4506 (2008)).	—	—
Louisiana	Food & Drug	—	LA Food & Drug law requires a written prescription for Schedule II substances except in an emergency situation. The law does not address electronic prescriptions. LA. Rev. Stat. Ann. § 40:978(A), (B) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Maine	Pharmacy	ME Pharmacy law permits noncontrolled drugs to be prescribed via e-mail or the World Wide Web if regulatory requirements, including e-signatures and secure transmission, are met. Me. Rev. Stat. Ann. tit. 32, § 13702-A(31) (2008); 02-392-019 Me. Code R. § 3 (2009).	ME Pharmacy law requires written prescriptions for controlled substances, particularly Schedule II controlled substances, for which requirements are spelled out in a ME Department of Public Safety regulation that is incorporated by reference into the Pharmacy regulations. Note also that the regulation authorizing e-prescriptions "Via Email or the World Wide Web" is limited to "Noncontrolled Drugs." However, the ME Department of Public Safety regulation provides for a waiver process whereby a provider or pharmacy may apply for a waiver from the requirements for security prescription blanks. The applicant must demonstrate that an alternative system would equally protect against forgery or alteration of an original prescription. Waiver process potentially could be used to gain approval for the use of e-prescriptions for controlled substances. 02-392-019 ME. Code R. § 2 (2009); 16-230-001 ME Code R. § 2, 4, 5 (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Maryland	Pharmacy	MD Pharmacy law permits "electronically transmitted" prescriptions and requires that they be accurately and securely transmitted. Standards do not appear to impede e-prescribing. MD Code Ann., Health Occ. §12-313(b)(15) (2008); MD. Code Regs. 10.34.20.02 (2009).	—	—
Maryland	Medicaid	Medicaid pharmacy services regulations define "prescription" as including both fax and "electronic" orders. Does not appear to impede e-prescribing. MD. Code Regs. 10.09.03.01(26) (2009).	—	—
Maryland	Food & Drug	—	State Food, Drug and Cosmetics Act provides that a prescription for a controlled dangerous substance must be oral or written and if written, must be on a separate prescription form. May impede e-prescribing of controlled substances. MD. Code Ann., Health-Gen. § 21-220(a), (b) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Maryland	Criminal Law/ Controlled Dangerous Substances	—	MD Criminal Law relating to controlled substances (and the corresponding regulations of the state Department of Health and Mental Hygiene) generally require a manually signed, written prescription for a Schedule II controlled substance. Prescriptions for Schedule III–V controlled substances may be written, faxed, or oral (provided that any oral prescription is reduced to writing by the pharmacist). The state regulations adopt and reiterate the text of DEA regulations relating to controlled substances including those that address the manner of issuance and requirements for prescriptions. MD. Code Ann., Crim. Law § 5-501(a) (2008); MD. Code Ann., Crim. Law § 5-504(a) (2008); MD. Code Regs. 10.19.03.07(D) (2009) (incorporating 21 CFR § 1306.05—manner of issuance of prescriptions); 10.19.03.08(A) (2009) (incorporating 21 CFR § 1306.11 requirement of prescription—Schedule II); 10.19.03.09(A) (2009) (incorporating 21 CFR § 1306.21—requirement of prescriptions listed in Schedules III, IV, and V).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Massachusetts	Pharmacy	MA Pharmacy law permits e-prescriptions. However, e-prescriptions for Schedule II substances are permitted only in emergency situations and must be immediately reduced to writing by the dispensing pharmacist. 247 Mass. Code Regs. 5.02(1) (2008); 247 Mass. Code Regs. 5.03(2) (2008).	E-prescriptions for Schedule II substances are permitted only in emergency situations and must be immediately reduced to writing by the dispensing pharmacist. 247 Mass. Code Regs. 5.03(2), (3) (2008).	—
Massachusetts	Medical Doctors	—	—	MA Medical Doctor law encourages e-prescribing. Requires that applicants for physician licensure show competency in e-prescribing. In addition, such competency is an eligibility requirement for a state program offering repayment assistance for medical school loans. Mass. Gen. Laws Ann. ch. 112, § 2 (2009); Mass. Gen. Laws Ann. ch. 111, § 25N(a) (2009).
Massachusetts	Medicaid	MA Medicaid law appears to allow e-prescriptions provided that they are permissible under state and federal law. 130 Mass. Code Regs. 406.411(A) (2008); accord 130 Mass. Code Regs. 410.461(A), 433.441(A) (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Massachusetts	Food & Drug	MA Food & Drug law defines "written prescription" as including prescriptions that have been issued electronically and bear the electronic signature of the prescriber and other standard content requirements for prescriptions. Mass. Gen. Laws. Ann. ch. 94, § 187 (2009).	—	—
Massachusetts	Department of Public Health/ Standards for Prescription Format and Security	MA Dept. of Public Health regulations expressly permit e-prescriptions and establish security standards. 105 Mass. Code Regs. 721.020(A)(3) (2008).	MA Public Health regulations permit e-prescriptions for controlled substances to the extent permitted by state law and DEA and other federal regulations. 105 Mass. Code Regs. 721.030 (2008).	—
Massachusetts	Regulation of Trade/Controlled Substances Act	—	The MA Controlled Substances Act permits an e-prescription for a controlled substance unless otherwise prohibited by law. Mass. Gen. Laws Ann. ch. 94C, § 23(g) (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Michigan	Pharmacy	MI Pharmacy law has detailed provisions addressing e-prescriptions, including content and security standards. The law permits pharmacists to dispense • e-prescriptions for noncontrolled substances transmitted by both in-state and out-of-state prescribers; • e-prescriptions for Schedule III–V substances transmitted by in-state prescribers; and • e-prescriptions for Schedule III–V substances transmitted by out-of-state prescribers in IL, MN, or who reside adjacent to the land border between MI and an adjoining state. Otherwise, pharmacists may not dispense prescriptions for controlled substances transmitted by out-of-state prescribers. Mich. Comp. Laws § 333.17708 (2009); Mich. Comp. Laws Ann. § 333.17703(6) (2009); Mich. Comp. Laws Ann. § 333.17754 (2009); Mich. Comp. Laws Ann. § 333.17751(1), (2) (2009); Mich. Comp. Laws § 333.17763(e) (2009); Mich. Admin. Code r. 338.479b(8)-(13) (2009); Mich. Admin. Code r. 338.3162a (2009).	For Schedule II controlled substances, MI Pharmacy law defers to MI Controlled Substances law, which requires a written prescription for a Schedule II controlled substance. Mich. Comp. Laws Ann. § 333.17754 (2009).	Pharmacy law requires the transaction service vendor to retain a secured copy of the prescription for a minimum of 1 year. Mich. Admin. Code r. 338.479b(8)-(13) (2009). Automated data processing system for recording prescriptions is permitted and must be able to print out an audit trail for any specified strength and dosage form of a controlled substance by either brand or generic name or an audit trail of controlled substance prescriptions written for a particular patient or by a particular practitioner upon request. Does not require daily hard-copy printouts.

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Michigan	Public Health Code/ Controlled Substances	—	MI Public Health Code/ Controlled Substances law authorizes e-prescriptions for: • Schedule III–V controlled substances transmitted by in-state prescribers and • Schedule III–V controlled substances by out-of-state prescribers who are IL or MN physicians or physicians who reside adjacent to the land border between MI and an adjoining state. Mich. Comp. Laws Ann. § 333.7333(7) (2009); Mich. Comp. Laws Ann. § 333.7405(1)(e) (2009); Mich. Admin. Code r. 338.3162(4) (2009). Prescriptions for Schedule II controlled substances must be written on a prescription form. In an emergency situation, a pharmacist may dispense a Schedule II controlled substance on an oral prescription which is followed within 7 days by a written prescription form that is delivered by hand or mailed to the dispensing pharmacy. Mich. Comp. Laws Ann. § 333.7333(1)-(4), (7) (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Minnesota	Pharmacy	MN Pharmacy law permits e-prescriptions. Generally, requires e-prescription transmitted from the prescriber to the pharmacy to comply with rules of the federal Drug Enforcement Administration. Minn. R. 6800.3000(3) (2008).	Schedule II substances require a written drug order, except where a fax or oral order reduced to writing is permissible (in an emergency). Minn. R. 6800.6200(3) (2008).	Regulations on pharmacy's electronic data processing equipment specifically require daily printout of controlled substance prescriptions. Also require that the "original prescription" be retained on file (to be available in the event of a computer breakdown) and that the pharmacist compare the "original prescription" to the information entered into the computer, implying that an electronic prescription may not be an "original prescription." Minn. R. 6800.3950(1a)-(4) (2008).
Minnesota	Health/Drugs, Controlled Substances	—	Except in emergency situations, a prescription for a Schedule II controlled substance must be written in ink. Prescriptions for Schedule III or IV controlled substances may be written or oral. Minn. Stat. Ann. § 152.11(1), (2) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Minnesota	Insurance/Health Care Cost Containment	MN Insurance law requires that an e-prescription drug program be established by January 1, 2011. Minn. Stat. Ann. § 62J.497(2)(a), (2)(b) (2008). The statute contains detailed technical standards for electronic prescriptions. See Minn. Stat. Ann. § 62J.497(2), (3) (2008).	—	—
Mississippi	Pharmacy	Pharmacy law does not define "electronically transmitted." Allows pharmacist to accept electronically transmitted prescriptions (except Schedule II). 50-018-001 Miss. Code R. art. XII (2008).	Pharmacy law permits prescriptions for Schedule II only in writing or via fax. 50-018-001 Miss. Code R. art. XIX (2008).	Pharmacy law requires pharmacists to file and maintain paper copy of electronically transmitted prescription. 50-018-001 Miss. Code R. art. XIII (2008).
Mississippi	Medical Doctors	Define e-prescribing as including computer-to-computer transmission. Permit e-prescribing with exceptions for certain specified drugs not "controlled substances" under federal law, e.g., Nalbuphine Hcl. 50-013-25 Miss. Code R. § 10 (2008)	Permit only paper or computer-to-fax or fax-to-fax transmission of controlled substance prescription information. 50-013-25 Miss. Code R. § 9(6) (2008). Require compliance with Title 21 CFR, Part 1306.50-013-25 Miss. Code R. § 9 (2008).	—
Mississippi	Medicaid	Medicaid laws generally recognize electronic transmission and e-prescribed orders (i.e., use the terms) but do not define and do not specify requirements. 13-000-011 Miss. Code R. § 31.27 (2008).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Missouri	Pharmacy	MO Pharmacy law permits e-prescriptions, defined to encompass both fax and other electronic transmissions. MO. Code Regs. Ann. tit. 20, § 2220-2.085(2) (2008); MO. Code Regs. Ann. tit. 20, § 2220-2.085(1) (2008).	A prescription for a controlled substance must comply with all requirements of federal and state controlled substance laws. MO. Code Regs. Ann. tit. 20, § 2220-2.018(1)(K) (2008).	Pharmacy regulation specifies that the patient has the option of having an electronically produced prescription sent electronically to a pharmacy or provided as a hard copy generated from the prescriber's electronic prescribing system. MO. Code Regs. Ann. tit. 20, § 2220-2.085(2) (2008).
Missouri	Public Health and Welfare/Drug Regulations/ Narcotic Drug Act	—	Controlled substance laws impede e-prescribing. Prescriptions for Schedule III–V substances may be transmitted by electronic transmission, but must be reduced to writing by the pharmacist. (In limited circumstances, Schedule II prescriptions may also be transmitted electronically.) MO. Code Regs. Ann. tit. 19, § 30-1.062 (2008). Pharmacist who dispenses controlled substances under a prescription transmitted by electronic computer transmission must verify with the practitioner within 30 days of the filling of the prescription that it was authorized by the practitioner either via telephone or by sending the practitioner a copy of a computer printout, which the practitioner must verify, sign, and return to the pharmacy. MO. Code Regs. Ann. tit. 19, § 30-1.048(7)-(10) (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Missouri	Public Health and Welfare/Old Age Assistance, Aid to Dependent Children/Health Care Technology Fund	—	—	MO's General Assembly has established a "Health Care Technology Fund" that is to be used to improve health care technology, including e-prescribing. The MO HealthNet Oversight Committee was to have reported recommendations to the governor and general assembly regarding expenditures from the fund by January 1, 2008. Mo. Rev. Stat. Ann. § 208.975(1), (2) (2009); Mo. Rev. Stat. Ann. § 208.978(1), (3) (2009).
Montana	Pharmacy	MT Pharmacy law permits prescriptions by "electronic transmission" for noncontrolled substances, but does not define that term. However, the regulations appear to encompass both computer-to-computer and fax transmissions. Mont. Code Ann. § 37-7-101(31) (2007); Mont. Admin. R. 24.174.523(1)-(4) (2009).	Prescriptions for Schedule II controlled substances may be transmitted electronically only in limited cases. It is unclear whether prescriptions for Schedule III–V controlled substances may be electronically transmitted other than by fax. See Mont. Admin. R. 24.174.523(3)(2009) (pharmacist may dispense Schedule III–V drug "pursuant to either a written prescription signed by a practitioner or a copy of a written, signed prescription transmitted by the practitioner… to the pharmacy by electronic means").	On their face, the pharmacy regulations appear to require that electronically transmitted prescriptions be transcribed by the pharmacist, rather than retained in electronic format. If this is correct, this requirement would impede e-prescribing. See Mont. Admin. R. 24.174.523(4)(e) (2009) ("A printed, nonfading copy of an electronically transcribed prescription will be maintained in the pharmacy for a period of 2 years").

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Montana	Food & Drug —		MT Food & Drug law permits only written or oral prescriptions (that are reduced to writing by the pharmacist) for habit-forming drugs or drugs requiring professional supervision for safe use. Mont. Code Ann. § 50-31-307(1), (2) (2007). —	
Montana	Health and Safety/ Controlled Substances —		MT Controlled Substances law requires a written prescription for Schedule II dangerous drugs (i.e., controlled substances) except in emergency situations. Schedule III or IV drugs may be dispensed based on either a written or oral prescription. Although the Controlled Substances law defines "prescription" to include an electronically transmitted prescription, it does not appear to otherwise authorize e-prescriptions. Mont. Code Ann. § 50-32-208(1)-(3) (2007). MT follows federal law regarding the scheduling of drugs unless the state Board of Pharmacy disagrees with the federal decision. Mont. Code Ann. § 50-32-203 (2007). —	

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Nebraska	Pharmacy	NE Pharmacy law permits electronic transmission (defined to include computer-to-computer transmission) of prescriptions for noncontrolled drugs. Has specific requirements for digital signatures including the following: • it is unique to the person using it; • it is capable of verification; • it is under the sole control of the person using it; • it is linked to data in such a manner that if the data are changed, the digital signature is invalidated; and • it conforms to rules and regulations adopted and promulgated by the [NE] Secretary of State. Neb. Rev. Stat. Ann. § 38-2870(3)-(5) (2009); Neb. Rev. Stat. Ann. § 38-2821 (2009); Neb. Rev. Stat. Ann. § 86-611(2) (2009).	—	Pharmacists (or pharmacist interns) must sign and date "the face" of Schedule II controlled substance prescriptions when they are dispensed and keep on file an original hard copy of Schedule II controlled substance prescriptions except when otherwise allowed by the Uniform Controlled Substances Act. 175 Neb. Admin. Code § 8-005.03 (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Nebraska	Medicaid	NE Medicaid regulations indirectly authorize e-prescribing. The regulations refer to e-prescribing as an exception to the requirement that a written prescription be executed on a tamper-resistant pad. 471 Neb. Admin. Code §§ 1-002.02N, 1-002.02N1 (2009).	—	—
Nebraska	Crimes and Punishments/Drugs and Narcotics/ Noncode Provisions	NE Crimes and Punishments law permits e-prescriptions for noncontrolled drugs. Neb. Rev. Stat. Ann. § 28-1437(2), (3) (2009).	NE Crimes and Punishments law permits legend drugs to be transmitted electronically. A Schedule II controlled substance drug may not be dispensed without a written, signed prescription except in emergencies or other limited situations. Schedule III–V drugs may be dispensed based on a written prescription, the fax of a written prescription, or an oral order. There is no provision that expressly permits e-prescribing Schedule III–V drugs. Neb. Rev. Stat. Ann. § 28-414(1)(a), (1)(b), (1)(c), (2)(a) (2009).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Nevada	Pharmacy	NV Pharmacy law permits e-prescriptions (including computer-to-computer transmissions) for noncontrolled drugs. Nev. Rev. Stat. Ann. § 639.2353 (2009); Nev. Admin. Code § 639.7105 (2008).	E-prescriptions for Schedule II controlled substances are not permitted. The pharmacy regulations permit e-prescriptions for "dangerous drugs" or controlled substances listed in Schedules III–V. A prescription for a controlled substance may not be given by electronic transmission unless authorized by federal law. Nev. Rev. Stat. Ann. § 639.2353(5) (2009); Nev. Admin. Code § 639.7102(8) (2008); Nev. Admin. Code § 639.7105(1) (2008).	The state has detailed requirements for e-prescribing, some of which appear likely to impede e-prescribing. One regulatory provision that may impede e-prescribing is the requirement that a practitioner obtain a patient's consent to send a prescription electronically. Another regulatory provision appears to require that a pharmacist print a copy of a prescription transmitted electronically and retain the copy for 2 years. Nev. Admin. Code § 639.7105 (2008).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Nevada	Public Health and Safety/Controlled Substances	—	NV Controlled Substance statute provides that the state board of pharmacy may not adopt regulations governing the electronic transmission of controlled substances that are more stringent than federal law governing the electronic transmission of such substances. Under current NV Controlled Substance statute and regulations, except in limited situations or in an emergency, a prescription for a Schedule II controlled substance must be in writing. A prescription for a Schedule III, IV, or V controlled substance may be faxed to a pharmacy. Note: unlike the pharmacy regulations, the controlled substance regulations do not expressly permit electronic transmission of prescriptions for Schedule III–V controlled substances. Nev. Rev. Stat. Ann. § 453.385(3) (2009); Nev. Rev. Stat. Ann. § 453.256(1)-(3) (2009); Nev. Admin. Code § 453.430(4) (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Nevada	Public Health and Safety/Poisons; Dangerous Drugs and Hypodermics	NV Public Health and Safety law, which generally governs drugs that may be sold only by prescription, defines "prescription" as including electronic transmission of an order from the practitioner to the pharmacist. However, the statute and the implementing regulations do not substantively address e-prescribing, and require that prescriptions be written on a prescription blank or as an order on a patient's chart. Nev. Rev. Stat. Ann. 454.00961 (2009); Nev. Rev. Stat. Ann. § 454.223 (2009).	—	—
New Hampshire	Pharmacy	NH Pharmacy law permits e-prescriptions for noncontrolled substances, which include both facsimile prescriptions and other electronic prescriptions. N.H. Rev. Stat. Ann. § 318:47-c (2009); N.H. Rev. Stat. Ann. § 318:1(III), (XVI), (XXIV) (2009); N.H. Code Admin. R. Ann. Ph 704.03 (a)-(c) (2009).	NH Pharmacy law permits facsimile transmission for prescriptions for Schedule III–V controlled substances, but does not address other types of electronic transmission for controlled substances. Prescriptions for Schedule II controlled substances may be transmitted by facsimile only in limited circumstances. N.H. Code Admin. R. Ann. Ph 704.03(b)(3), (d)-(f) (2009).	Record-keeping requirements may impede e-prescribing. Pharmacies using automated data processing systems apparently must maintain a "hard copy of all prescriptions." Further, refills entered into a pharmacy's automated data processing system must be documented by a hard-copy printout of each day's controlled substance order refill data signed by the dispensing pharmacists or a bound log book or file signed daily by the dispensing pharmacists, attesting to the correctness of the refill information entered into the computer. N.H. Code Admin. R. Ann. Ph 703.05(j), (k), (o) (2009).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New Hampshire	Medical Doctors	NH Board of Medicine regulations define "prescription" to include an electronically transmitted prescription. N.H. Code Admin. R. Ann. Med 601.07 (2009).	—	—
New Hampshire	Medicaid	Regulations for the NH medical assistance program adopt the definition of "prescription" included in the NH pharmacy statutes. This definition encompasses both facsimile and other electronically transmitted drug orders. N.H. Code Admin. R. Ann. He-W 570.01(z) (2009); N.H. Rev. Stat. Ann. § 318:1(XVI) (2009).	—	—
New Hampshire	Food & Drug	NH Food & Drug law requires that drugs needing professional supervision for safe use be dispensed only upon a written prescription or an oral prescription reduced to writing by the pharmacist. E-prescriptions are not addressed. Compare to provisions in occupations code, pharmacies, which specifically state that a "written order" includes an electronic transmission prescription (see N.H. Rev. Stat. 318:1 (2009)). N.H. Rev. Stat. Ann. § 146:6(XI) (2009).	—	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New Hampshire	Occupations and Professions/ Controlled Drug Act	—	The NH Controlled Drug Act permits e-prescriptions properly executed, dated, manually or electronically signed… "in pursuance of regulations promulgated by the Dept. of Justice of the United States, under the provisions of the Comprehensive Drug Abuse Prevention Act of 1970, as amended." N.H. Rev. Stat. Ann. § 318-B:9(I), (III) (2009).	—
New Jersey	Pharmacy	NJ Pharmacy law permits electronic prescriptions (defined to include computer-to-computer transmissions) for noncontrolled substances and expressly makes an exception for state requirements for handwritten signatures and tamper-proof blanks with respect to e-prescribing. N.J. Stat. Ann. § 45:14-41 (2009); N.J. Admin. Code § 13:39-7.11(a)-(j) (2009).	If federal law were to permit e-prescriptions for controlled substances, NJ law would also permit such e-prescriptions. Otherwise, NJ law requires a signed written prescription prior to the dispensing of a Schedule II controlled substance. For Schedule III–V controlled substances, a written, oral, or facsimile prescription must be provided prior to dispensing. N.J. Stat. Ann. § 45:14-58(b) (2009); N.J. Admin. Code § 13:39-7.11(h), (i) (2009).	NJ Pharmacy regulations offer a good model for any states wishing to modify (for e-prescriptions) a common state record-keeping requirement that a pharmacist who fills a prescription must place his or her initials on the face of the original prescription. The NJ regulations allow pharmacists to place their initials or other personal identifier into the pharmacy's electronic data processing system. N.J. Admin. Code § 13:39-7.6(a), (c) (2009). It is unclear whether record-keeping requirements that mandate separate files for controlled substance prescriptions are fulfilled by maintaining controlled substance prescriptions in electronic form in a manner in which they may be segregated from other prescriptions. N.J. Admin. Code § 13:39-7.9 (2009).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New Jersey	Medical Doctors	Regulations of the NJ Board of Medical Examiners permit e-prescriptions (defined to include computer-to-computer transmissions) for noncontrolled substances. Require electronic signature or other method of validation. Require system used to transmit prescription to at least have encryption. N.J. Admin. Code § 13:35-7.4A (2009).	—	—
New Jersey	Food & Drug	—	NJ Food & Drug law requires a written prescription for a Schedule II controlled substance and a written or oral prescription for a Schedule III or IV controlled substance. The law does not address e-prescriptions. N.J. Stat. Ann. § 24:21-15(a), (b) (2009).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New Jersey	Health and Senior Services/Controlled Dangerous Substances	—	NJ regulations governing controlled dangerous substances require a written prescription for Schedule II controlled substances (except in limited cases) and a written or oral prescription (that is reduced to writing by a pharmacist) for Schedule III–V controlled substances. The regulations do not address electronic prescriptions. N.J. Admin. Code § 8:65-7.8(a), (d) (2009); N.J. Admin. Code § 8:65-7.13(a), (b) (2009) ; N.J. Admin. Code § 8:65-7.5(a) (2009).	—
New Jersey	Law and Public Safety/Division of Consumer Affairs/NJ Prescription Blank Program	NJ Consumer Affairs regulations exempt prescribers from the requirement of using the NJ Prescription Blank to prescribe drugs if they are lawfully prescribing drugs verbally, electronically, or by facsimile. N.J. Admin. Code § 13:45A-27.3(e), (f) (2009).	Prescribers are exempt from using NJ tamperproof prescription blanks for Schedule II controlled substances if the prescription is transmitted or prepared in "compliance with DEA regulations as set forth in 21 C.F.R. 1306.11(d), (e), (f) (g)." N.J. Admin. Code § 13:45A-27.3(f) (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New Mexico	Pharmacy	NM Pharmacy law permits electronic transmission (by any electronic device) of prescriptions for noncontrolled substances between "contracted" parties. N.M. Stat. Ann. § 61-11-2 (B), (M), (CC) (2008); N.M. Code R. § 16.19.6.23(A), (F) (2009).	NM Pharmacy regulations permit electronically transmitted prescriptions for controlled substances "to the extent permitted by federal law." However, the regulations also specifically require Schedule II controlled substance prescriptions to be written and manually signed by the practitioner, except in limited circumstances. Prescriptions for Schedule III or IV controlled substances must be: written and signed; a fax of a written and signed prescription; or an oral prescription reduced promptly to written form by the pharmacist. N.M. Code R. § 16.19.6.7(C) (2009); N.M. Code R. § 16.19.20.42(A), (B), (F) (2009).	An electronically transmitted prescription may serve as the hard-copy record of the prescription provided that it can be stored in its original format and is readily retrievable. N.M. Code R. § 16.19.6.23(A), (F) (2009).
New Mexico	Medical Doctors	The NM Physician Assistant Act and related regulations define "prescription" in a way that may or may not cover electronic prescribing. A "prescription" includes an order that goes "directly" from the prescriber to the pharmacist and an order that goes "indirectly" by means of a "written order signed by the prescriber." N.M. Stat. Ann. § 61-6.7.1(D) (2008); accord N.M. Code R. § 16.10.16.7(A) (2009).	—	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New Mexico	Food & Drug	The NM Drug, Device and Cosmetic Act defines "prescription" to include a prescription sent to a pharmacist by "electronic transmission," but this latter term is not defined. N.M. Stat. Ann. § 26-1-2(I) (2008).	—	—
New Mexico	Criminal Offenses/ Controlled Substances	—	The NM Controlled Substances Act defines "prescription" to include a prescription sent to a pharmacist by "electronic transmission," but this latter term is not defined and may refer only to fax transmission (particularly since the related controlled substance provisions do not authorize electronic prescriptions other than by fax—see below). N.M. Stat. Ann. § 30-31-2(S) (2008). NM Controlled Substances law requires a written prescription for Schedule II controlled substances (except in emergency situations) and a written or oral prescription for controlled substances in Schedules III or IV. N.M. Stat. Ann. § 30-31-18(A), (C), (G) (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New York	Pharmacy	NY Pharmacy regulations permit e-prescriptions (which include, but are not limited to, facsimile prescriptions) for noncontrolled substances. Require electronic signature and use of encryption in transmission. N.Y. Comp. Codes R. & Rags. tit. 8, § 63.6(a)(7) (2009).	"[E]lectronically transmitted prescription"… excludes any such prescription for a controlled substance under Article 33 of the Public Health Law. N.Y. Comp. Codes R. & Regs. tit. 8, § 63.6(a)(7)(i) (2009).	A Pharmacy regulatory requirement that may impede e-prescribing is the requirement that a pharmacy produce and retain a "permanent hard copy" of an e-prescription for 5 years. N.Y. Comp. Codes R. & Rags. tit. 8, § 63.6(a)(7) (2009).
New York	Medicaid	NY Medicaid law permits e-prescriptions unless they are prohibited by other law. Pharmacist must make a good faith effort to verify the practitioner's identity and validity of the prescription if the practitioner is unknown to the pharmacist. N.Y. Comp. Codes R. & Regs. tit. 18, § 505.3(b)(6) (2009).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
New York	Public Health/ Controlled Substances	—	NY Public Health/Controlled Substances laws (statute and regulations) currently require a written, manually signed prescription on an official NY prescription form for controlled substances except in emergencies or other limited situations. Even in situations where a fax prescription is permitted, the practitioner must deliver to the pharmacist an official NY prescription form within 72 hours. N.Y. Pub. Health Law § 3332(1), (2) (2009); N.Y. Pub. Health Law § 3333(1) (2009); N.Y. Comp. Codes R. & Regs. tit. 10, § 80.67(a), (b), (e), (f) (2009); N.Y. Comp. Codes R. & Regs. tit. 10, § 80.69(a), (e), (f) (2009). However, NY Public Health/ Controlled Substances law also expressly permits the use and transmission of e-prescriptions "pursuant to regulations" and expressly authorizes the promulgation of regulations with respect to the prescribing, dispensing, use, and transmission of e-prescriptions in lieu of the official NY prescription form. Such regulations do not appear to have been promulgated. N.Y. Pub. Health Law § 3338(2), (3) (2009); N.Y. Pub. Health Law § 3308(5) (2009).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
North Carolina	Pharmacy	NC Pharmacy regulations expressly permit electronic transmissions (distinct from fax transmissions) and have basic content requirements. The Pharmacy Board's regulations thus implicitly interpret "written order for prescription drug" (statutory definition of prescription) as including electronically transmitted prescriptions. N.C. Gen. Stat. § 90-85.3 (2008); 21 N.C. Admin. Code 46.1813 (2008).	—	NC Pharmacy regulations require each pharmacist who enters prescription information into an automated data processing system to document the correctness of his or her entries by manually signing a daily printout, log book, or separate file. 21 N.C. Admin. Code 46.2303 (2008); 21 N.C. Admin. Code 46.2304(3) (2008).
North Carolina	Food & Drug	NC Food & Drug law requires a written prescription signed by the prescriber or an oral prescription reduced to writing. N.C. Gen. Stat. Ann. § 106-134.1(a) (2009).	—	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
North Carolina	Medicine and Allied Occupations/NC Controlled Substances Act	—	Under regulations governing controlled substances, compliance with the prescription requirements of the federal law, including the requirements presented in Part 1306 of Title 21 of the Code of Federal Regulations, is deemed compliant with NC Controlled Substances Act. 10A N.C. Admin. Code 26E.0301 (2008). Otherwise NC regulations require a written prescription for a Schedule II controlled substance (except in an emergency) and an oral or written prescription for Schedule III–IV controlled substances. N.C. Gen. Stat. § 90-106(a)-(c) (2009).	—
North Dakota	Pharmacy	ND Pharmacy regulations permit e-prescriptions (in addition to fax transmissions) except for prescriptions for Schedule II controlled substances. N.D. Admin. Code 61-04-05-02 (2008).	Schedule III–V controlled substance prescriptions may be prescribed electronically, but not Schedule II controlled substances. N.D. Admin. Code 61-04-05-03(1), (2) (2008).	A record-keeping requirement in ND Pharmacy regulations appears to be inconsistent with a paper-free e-prescribing system. Pharmacies using electronic data processing equipment for prescriptions must produce a daily hard-copy summary of controlled substance transactions. N.D. Admin. Code 61-02-06-02(3) (2008).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
North Dakota	Food & Drug	—	ND Food & Drug law requires a written prescription for a Schedule II controlled substance, except in emergency situations or other limited circumstances. Schedule III–V controlled substances require a written prescription or an oral prescription that is promptly reduced to writing. In limited circumstances, a faxed prescription is permitted for these substances. N.D. Cent. Code § 19-03.1-22 (2009).	—
Northern Mariana Islands	Food & Drug [Regulations Governing the Importation, Storage, Sales and Distribution of Drugs and Pharmaceutical Products]	—	CNMI Food & Drug regulations require a handwritten prescription for a Schedule II controlled substance. Otherwise, prescriptions for a controlled substance must comply with federal regulation and with the CNMI definition of "prescription" which permits a written, facsimile, or telephone order. 140 NMIAC 50.2-001(g) (2007); 140 NMIAC 50.2-001(aa) (2007).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Ohio	Pharmacy	OH Pharmacy statute requires that a prescription received electronically be recorded in writing. Prescriptions transmitted electronically by a board-approved electronic prescription transmission system fulfill this requirement and are treated as the original prescription under the Ohio Pharmacy regulations. Prescriptions transmitted electronically by other means (e.g., nonapproved systems) must be recorded in writing by the pharmacist and the hard copy recorded by the receiving pharmacist is treated as the original prescription. Ohio Rev. Code Ann. § 4729.37 (2009); Ohio Admin. Code 4729-5-01(H), (N) (2009). Nonetheless, it appears that even prescriptions received by approved systems must be "printed to document the dispensing." Ohio Admin. Code 4729-5-21(F) (2009).	OH Pharmacy law/regulations expressly permit the use of an approved e-prescription transmission system to fax a controlled substance prescription to a pharmacy. The regulations do not expressly permit computer-to-computer transmission of prescriptions for controlled substances. Ohio Admin. Code 4729-5-13(B), (E) (2009).	Pharmacy regulations require an e-prescription transmission system to use specified means of identifying users and prohibit relying solely on the use of a password. System must also include • a manual signature on a hard-copy record; • a magnetic card reader; • a bar code reader; • a thumbprint reader or other biometric method; • a proximity badge reader; • a board-approved system of randomly generated personal questions; • a printout of every transaction that is verified and manually signed within a reasonable period of time by the individual who prescribed, administered, or dispensed the dangerous drug; • other effective methods for identifying individuals that have been approved by the [state] board [of pharmacy]; and • a method relying on a magnetic card reader, a bar code reader, a proximity badge reader, or randomly generated questions for identification must also include a private personal identifier, such as a password, for entry into a secure mechanical or electronic system. Ohio Admin. Code 4729-5-01(H), (N) (2009).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Ohio	Medicaid	OH Medicaid regulations list e-prescriptions as an acceptable alternative to written prescriptions on tamper-resistant forms. Ohio Admin. Code 5101:3-9-06 (2009).	—	OH Medicaid law authorizes the Medicaid program to establish an e-prescribing system which would require a provider to prescribe electronically if the provider was one of the top 10 Medicaid prescribers for Medicaid recipients receiving hospital services in the previous year. In addition, the Ohio legislature requires a quarterly report from the Medicaid program that includes an update of the progress made on the development of "infrastructure policies for electronic health records and e-prescribing." Ohio Rev. Code Ann. § 5111.083 (2009); Ohio Rev. Code Ann. § 5111.091 (2009).
Ohio	Food & Drug	OH Food & Drug law permits e-prescriptions for drugs. Ohio Rev. Code Ann. § 3715.64(A)(12) (2009).	—	—
Ohio	Health-Safety-Morals/Controlled Substances	—	OH Controlled Substances law does not address e-prescriptions. It requires a written prescription for a Schedule II controlled substance, except in an emergency situation when an oral prescription is permitted. Ohio Rev. Code Ann. § 3719.05 (2009).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Oklahoma	Pharmacy	OK Pharmacy law permits prescriptions to be "transmitted" by means other than verbal if certain requirements are met, including, among other things, that no intervening person alter the prescription order and that equipment for receipt of prescription orders be maintained so as to ensure against unauthorized access. Okla. Admin. Code § 535:15-3-15.1 (2007).	—	OK Pharmacy law includes some provisions that may burden e-prescribing: • A statute requiring that prescriptions received other than by "written communication" must be recorded in writing by the pharmacist. It is not clear whether this would apply to an e-prescription since "written communication" is not defined. See Okla. Stat. Ann. tit. 59, § 353.13A(A) (2009). • A pharmacy regulation requiring (citing federal regulation) that a pharmacy using an automated data processing system to maintain prescription files must either: (1) generate nightly reports for prescriptions for Schedule II and other controlled substances that are verified and signed by the pharmacist or (2) maintain a bound log book or separate file for controlled substance prescriptions in which dispensing pharmacists sign a daily statement verifying that the information entered into the computer system is correct. See Okla. Admin. Code § 535:15-3-21(d) (2007).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Oklahoma	Medicaid	OK Medicaid regulations require the retention of original written prescriptions. It is not clear whether e-prescriptions are considered "original written prescriptions." Okla. Admin. Code § 317:30-5-70.2 (2007).	—	As part of the OK Medicaid Reform Act of 2006, the OK Health Care Authority was required to design and implement an e-prescribing pilot program. A report of the pilot program was to be submitted to the Governor and the Legislature within 18 months of the start of the program. Okla. Stat. Ann. tit. 56, § 1011.4(B), (C) (2009).
Oklahoma	Food & Drug	The OK Drug, Medical Devices, and Cosmetics law expressly addresses written and oral prescriptions but not e-prescriptions. Okla. Stat. Ann. tit. 63, § 1-1409(k) (2009).	—	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Oklahoma	Public Health and Safety/Uniform Controlled Dangerous Substances Act	—	OK Controlled Dangerous Substances law requires a written, signed prescription for a Schedule II controlled substance except in emergency situations when an oral prescription reduced to writing by the pharmacist is permitted. In addition, Schedule II prescriptions to a home infusion pharmacy or for long-term care or hospice patients may be faxed. Prescriptions for Schedule III–V drugs may be written, faxed, or oral (if reduced to writing by the pharmacist). E-prescribing is not addressed. Okla. Stat. Ann. tit. 63, § 2-309(A), (B), (F) (2009); Okla. Admin. Code § 475:30-1-4(a), (d), (f) (2007); Okla. Admin. Code § 475:30-1-10(a) (2007).	OK Controlled Substances law appears to provide for the transmission of a prescription to a pharmacy by "electronic transmission" (in addition to facsimile transmission), but the statutory and regulatory details relate to facsimile transmission. Moreover, an e-prescription with a computer-generated signature is to be treated as a "call-in prescription" and, accordingly, must be reduced to writing by the pharmacist. Okla. Stat. Ann. tit. 63, § 2-309(A)(2) (2009); Okla. Admin. Code § 475:30-1-4(a) (2007).
Oregon	Pharmacy	OR Pharmacy law permits electronically transmitted prescriptions for noncontrolled substances by practitioners licensed within the state. OR. Rev. Stat. Ann. § 689.005(31) (2007); OR. Admin. R. 855-006-0015(1) (2009); OR. Admin. R. 855-019-0210(6) (2009).	Electronically transmitted prescriptions for controlled substances are not allowed, unless they are permitted by federal regulations. OR Pharmacy law generally adopts federal regulations with respect to requirements for controlled substance prescriptions. In addition, OR uses the federal schedules of controlled substances. OR. Admin. R. 855-080-0085 (2009); OR. Admin. R. 855-080-0020 (2009).	Prescriptions received electronically may be retained electronically. OR. Rev. Stat. Ann. § 689.508 (2007); see also OR. Admin. R. 855-041-0060(1)(a) (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Oregon	Medicaid	OR Medicaid law requires the state Department of Human Services to seek a federal waiver to permit e-prescribing in the Medicaid program. The state follows federal law in requiring that written prescriptions for Medicaid recipients either be written on a tamper-resistant pad or transmitted electronically to be eligible for reimbursement. OR. Rev. Stat. Ann. § 414.327 (2007); Or. Admin. R. 410-121-0145(3) (2009).	—	—
Oregon	Alcoholic Liquors; Controlled Substances; Drugs	—	OR Controlled Substances law permits e-prescriptions (which include computer-to-computer transmissions) except for prescriptions for Schedule II controlled substances (or prescriptions for lethal injections, poisons, "death with dignity" drugs, or juvenile detainee medicine) which must be in writing. In emergency situations, Schedule II drugs may be prescribed orally or electronically if the prescription is reduced to writing and filed by the pharmacy. Electronic prescriptions for other controlled substances may be stored electronically. OR. Rev. Stat. Ann. § 475.185 (2007); OR. Rev. Stat. Ann. § 475.188 (2007); OR. Rev. Stat. Ann. § 475.005(5), (6), (14), (19) (2007).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Pennsylvania	Pharmacy	PA Pharmacy law permits electronically transmitted prescriptions (including computer-to-computer, computer-to-fax machine, or e-mail transmissions) other than for Schedule II controlled substances. Requires standard information in prescription and encryption or other technology to prevent access, alteration, manipulation, or use by any unauthorized person. 49 PA. Code § 27.201 (2009).	PA Pharmacy law requires that prescriptions for Schedule II controlled substances be manually signed by the prescriber. A fax prescription for a Schedule II controlled substance is permitted if the prescription is for direct administration or for a long-term care or hospice patient. A pharmacist may dispense a prescription that is electronically transmitted or faxed for a Schedule III–V controlled substance. 49 PA. Code § 27.201(b) (2009); 49 PA. Code § 27.18(b)(2) (2009); 49 PA. Code § 27.20 (2009).	One requirement that may impede e-prescribing relates to refills for nonproprietary drugs. Prescriptions for nonproprietary drugs which are to be refilled more times than permitted for a Schedule III–V controlled substance (i.e., more than five times in the 6-month period from the date of the prescription) must specifically indicate the number of refills "in the original handwriting of the prescriber." 49 PA. Code § 27.18(j) (2009).
Pennsylvania	Medical Doctors	—	PA Medical Doctor regulations accord with the requirement in its Controlled Substances regulations that emergency oral prescriptions for Schedule II controlled substances must be followed by a written prescription within 72 hours. 49 PA. Code § 16.92(a)(5) (2009).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Pennsylvania	Medicaid	PA Medicaid regulations on content of prescriptions address only written or oral prescriptions. 55 PA. Code § 1121.52 (2009).	—	Parenthetical note regarding PA prescription requirements in public assistance programs: The PA Department of Aging administers a prescription program for low-income senior citizens who are not enrolled in the Department of Public Welfare's Medicaid prescription benefit. Providers in that program must retain original hard copy prescriptions for 4 years. An original hard copy prescription is either the original written prescription from the prescriber or an oral order that has been reduced to writing by the pharmacist and bears the pharmacist's handwritten signature or initials. In addition, the pharmacy must maintain a daily hard copy record of filled and refilled prescriptions bearing the handwritten signature or initials of the pharmacist who filled or refilled the prescription. 6 PA. Code § 22.62(c) (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Pennsylvania	Food & Drug [Health and Safety/Controlled Substance, Drug, Device, and Cosmetic Act]	—	PA Controlled Substances/ Drugs, Devices, and Cosmetics law requires a written, manually signed prescription for Schedule II controlled substances (except in an emergency situation) and a written or oral prescription for Schedule III–IV substances. E-prescribing is not addressed. 35 PA. Stat. Ann. § 780-111 (2008); 35 PA. Stat. Ann. § 780-113(a)(15) (2008); 28 PA. Code § 25.41 (2009); 28 PA. Code § 25.53 (2009).	Some regulatory record-keeping requirements may impede e-prescribing. Prescription orders for Schedule I and II controlled substances must be maintained in a separate prescription file. Prescription orders for Schedule III–V controlled substances may be maintained either in a separate prescription file or "in such form that they are readily retrievable from the other pharmacy prescription records" such as by being marked with a red "C." No acceptable means specified for designating e-prescriptions. 28 PA. Code § 25.56 (2009).

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Puerto Rico† † The conclusions for PR are based on an analysis of PR statutes; PR regulations are not readily available in English.	Pharmacy	PR Pharmacy law permits e-prescribing (which includes digital transmission) for noncontrolled substances, but only as a preliminary step to initiate the prescription filling process. The patient or a representative must hand over the "original" prescription to the pharmacist before the medication is actually dispensed. The e-prescription may be transmitted to the pharmacy by the patient as well as by the prescriber. In the case of an emergency, medication may be dispensed based upon an e-prescription transmitted by the prescriber, which is transcribed by the pharmacist upon receipt. The prescriber must deliver a written prescription to the pharmacy within 120 days. P.R. Laws Ann. tit. 20, § 410a(c), (e)-(g), (m) (2006).	PR Pharmacy/Pharmacist law defers to the Puerto Rico Controlled Substances Act and to the Federal Controlled Substances Act with respect to dispensing and record-keeping requirements for controlled substances. P.R. Laws Ann. tit. 20, § 410c(a) (2006).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Puerto Rico† † The conclusions for PR are based on an analysis of PR statutes; PR regulations are not readily available in English.	Health and Sanitation/ Controlled Substances	—	PR Controlled Substances law requires a written prescription for a Schedule II controlled substance except that in an emergency situation, an oral prescription is permitted (which must be backed up by a written prescription within 48 hours). Schedule III or IV substances may be prescribed through a written or oral prescription. E-prescribing is not addressed. With respect to the scheduling of controlled substances, PR defers to federal law: • by excluding from the schedules of controlled substances any nonnarcotic substance that, under the Federal Food, Drug and Cosmetic Act, may be sold without a prescription. • by following the Federal Controlled Substance Act with regard to the designation, reclassification, or removal of any substance under that Act, unless the state Secretary of Health objects to the federal determination. P.R. Laws Ann. tit. 24, § 2308 (2006); P.R. Laws Ann. tit. 24, § 2201(e), (f) (2006).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Rhode Island	Pharmacy	RI Pharmacy law permits e-prescriptions for noncontrolled substances and defers to the RI Controlled Substances Act, as well as other applicable state and federal laws, with respect to prescriptions for controlled substances. A patient has the right to choose the manner in which the patient's prescription is transmitted to the pharmacy. 14-130-001 R.I. Code R. §§ 8.4, 8.43 (2009).	RI Pharmacy law cites federal requirements as • permitting the electronic transmission of a prescription for a controlled substance only when it is a copy of an original prescription signed by the prescriber and • prohibiting electronic signatures for controlled substance prescriptions. 14-130-001 R.I. Code R. § 8.43(a), (b) (2009).	Pharmacies receiving e-prescriptions need not print hard copies of the prescriptions so long as they have the capacity to retrieve a hard copy from the pharmacy's computer memory. 14-130-001 R.I. Code R. §§ 8.4 (2009).
Rhode Island	Medicaid	RI Medicaid regulations generally require a written, manually signed prescription on a specified form (MA-509) for drugs dispensed to a Medicaid recipient. 15-040-004 R.I. Code R. § VII(E) (2009); 15-040-004 R.I. Code R. § IX (2009).	Prescriptions for Schedule II substances must be on specific forms. 15-040-004 R.I. Code R. § VII(A) (2009);15-040-004 R.I. Code R. § IX(C) (2009);15-040-004 R.I. Code R. § XVII(A) (2009).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Rhode Island	Food & Drug Law [Uniform Controlled Substances Act/RI Foods, Drugs and Cosmetics Act]	The RI Food, Drugs and Cosmetics Act contemplates e-prescriptions (but does not define e-prescriptions). R.I. Gen. Laws § 21-31-15(b)(1)(2009). Habit-forming or other drugs that require professional supervision for safe use require a written prescription or an oral prescription that has been reduced to writing. R.I. Gen. Laws § 21-31-15(a)(11) (2009).	The RI Uniform Controlled Substances Act requires a written, signed, and dated prescription for a Schedule II controlled substance in most circumstances. Controlled substance prescriptions must be on 2-part forms, with the pharmacist retaining the original and delivering the duplicate copy to the Director of Health. The Director of Health has been granted the authority to promulgate rules and regulations for the purpose of adopting a system for electronic data transmission of prescriptions for controlled substances in Schedule II that would negate this paper-based requirement. R.I. Gen. Laws § 21-28-3.18 (2009).	The definition of "prescription" within the RI Food, Drugs, and Cosmetics Act provides that a prescription received by "word of mouth, telephone, or other means of communication" shall be "reduced promptly to writing by the pharmacist." It is not clear whether a pharmacist would be required to reduce an e-prescription to writing. R.I. Gen. Laws § 21-31-2(22) (2009). A pharmacy may use an automatic data processing system to meet record-keeping requirements for oral prescriptions, but that system is not free of paper requirements. To validate the accuracy of the prescription information entered into the computer, the pharmacy must either: • Maintain a bound log book, or separate file, in which each individual pharmacist involved in the dispensing shall sign a statement each day, verifying the correctness of the prescription information entered into the computer that day or • Provide a printout of each day's prescription information that is verified, dated, and signed by the individual pharmacist. R.I. Gen. Laws § 21-28-3.18 (2009).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
South Carolina	Pharmacy	SC statutorily permits electronically transmitting prescription drug orders including those transmitted by computer. Content requirements include name and address of practitioner, phone number for verbal confirmation, time and date of transmission, and name of intended receiving pharmacy (as well as other information required by federal or state law). S.C. Code Ann. § 40-43-86(F) (2007).	—	—
South Carolina	Health	SC Prescription Information Privacy Act permits and sets basic standards for e-prescribing for noncontrolled substances. S.C. Code Ann. § 44-117-320 (2007); S.C. Code Ann. § 44-117-340 (2007).	Department of Health regulations governing controlled substances require prescriptions for controlled substances to be in writing. Pharmacist is required to manually, in cursive handwriting, place a notation on a controlled substance prescription when originally filled that indicates the date filled, the identity or initials of the pharmacist dispensing the prescription, and, if different from the quantity prescribed, the quantity dispensed. Regulations note "The purpose of the manual handwriting is to assist in positively identifying the performer of the dispensing function." S.C. Code Ann. § 44-53-360 (2007); S.C. Code Ann. Regs. 61-4, Pt. 5 (505, 506.1, 508, 513) (2007).	Note that SC statutorily provides that e-prescriptions are to be treated like oral prescriptions: "All laws and regulations applicable to oral prescription drug orders apply to all computer to computer, computer to facsimile machine, electronic device to computer, email, or the transmission of the exact visual image of a document by way of electronic equipment prescription orders." S.C. Code Ann. § 44-117-340 (2007).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
South Dakota	Pharmacy	SD Pharmacy law does not currently address e-prescribing. Noncontrolled prescription drugs require a written or faxed prescription or an oral prescription reduced to writing and filed. S.D. Admin. R. 20:51:05:20 (2008).	Schedule II controlled substances require a manually signed prescription except in an emergency. Prescriptions for Schedule III and IV controlled substances may be faxed to the pharmacy. S.D. Admin. R. 20:51:05:15 (2008); S.D. Admin. R. 20:51:05:16 (2008); S.D. Admin. R. 20:51:05:17 (2008); S.D. Admin. R. 20:51:05:19 (2008).	Written and faxed prescriptions for all prescriptions must be maintained in hard copy for 2 years. S.D. Admin. R. 20:51:05:20 (2008); S.D. Admin. R. 20:51:20:03 (2008).
South Dakota	Food & Drug	—	Prescriptions for controlled substances must be written and manually signed. However, oral prescriptions for Schedule II drugs are permitted in an emergency if the pharmacist promptly reduces the oral prescription to writing and if the practitioner supplies a written prescription within 7 days. Fax prescriptions for Schedule III and IV drugs are permitted. S.D. Admin. R. 44:58:08:05 (2008); S.D. Admin. R. 44:58:08:13 (2008).	—
South Dakota	Crimes	—	A prescription for a Schedule II controlled substance or drug must be in writing, except in an emergency. S.D. Codified Laws § 22-42-2.1 (2009); S.D. Codified Laws § 22-42-2.2 (2009).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Tennessee	Pharmacy	TN Pharmacy law permits e-prescribing. Tenn. Code Ann. § 63-10-213(a) (2008); Tenn. Code Ann. § 63-10-204(38) (2008); Tenn. Comp. R. & Regs. 1140-3-.04(2) (2008); Tenn. Comp. R. & Regs. 1140-1-.01(11) (2008).	—	The requirement that a hard copy or exact image of the transmitted order be maintained in the pharmacy may burden e-prescribing. Tenn. Comp. R. & Regs. 1140-3-.04(2)(b) (2008).
Tennessee	Food & Drug	—	Schedule II controlled substances require a written prescription except in emergencies, when an oral prescription is acceptable if promptly reduced to writing and filed by the pharmacy. Tenn. Code Ann. § 53-11-308 (2008).	—
Texas	Pharmacy	Pharmacy regulations contain detailed provisions for e-prescriptions, including standard content requirements. In addition, provisions require a statement which indicates that the prescription has been electronically transmitted (e.g., faxed to or electronically transmitted to) and the full name of the designated agent if agent was used to transmit the prescription. 22 Tex. Admin. Code § 291.34(b)(4), (b)(6)(B) (2008).	TX Pharmacy law permits e-prescription drug orders except for Schedule II controlled substances. 22 Tex. Admin. Code § 291.34 (b)(4)(C) (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Texas	Medical Doctors	Medical Doctors are held to same standards in issuing prescriptions electronically as they are in traditional face-to-face settings. 22 Tex. Admin. Code § 174.4(b) (2008).	—	—
Texas	Medicaid	—	—	To the extent allowed by federal law, TX law permits the state Health and Human Resources Commission to adopt rules permitting e-prescribing within the state's Medicaid program. At present, however, the TX Administrative Code does not appear to include such rules. Tex. Hum. Res. Code Ann. § 32.102(a) (2007).
Texas	Food & Drug	—	Schedule II prescriptions must be on official state prescription form. Other prescriptions may be "electronically communicated," a term which is undefined. Tex. Health & Safety Code Ann. § 481.074(b), (g), (h), (k) (2007); Tex. Health & Safety Code Ann. § 481.075 (2007); 37 Tex. Admin. Code § 13.73(a) (2008)	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Utah	Pharmacy	UT Pharmacy Practice Act allows pharmacists to accept electronically transmitted prescriptions for noncontrolled substances subject to certain standards. Recognizes validity of electronic signatures. Requires inclusion of time and date of the transmission, the name of the pharmacy intended to receive the transmission, and identifying information of transmitting agent if one is used. Utah Code Ann. § 58-17b-602(1) (2008); Utah Code Ann. § 58-17b-102(29), (30) (60) (2008); Utah Admin. Code r.156-17b-613 (2008).	Prescriptions for controlled substances are governed by the UT Controlled Substances Act. Prescription orders for controlled substances (including prescription transfers) must be handled according to the rules of the Federal Drug Enforcement Administration. Utah Admin. Code r.156-17b-612(1) (2008); Utah Admin. Code r.156-17b-613(1) (2008).	—
Utah	Controlled Substances	—	UT Controlled Substances law appears to allow e-prescribing for controlled substances to the extent permitted under the federal Controlled Substances Act. The law requires a written prescription if a written prescription is required by the federal law. Otherwise, the law allows a prescription for a controlled substance to be "signed with an electronic signature of the prescriber." Utah Code Ann. § 58-37-6(7) (2008).	Prescription records of controlled substances may be maintained electronically so long as the original of each prescription is maintained in a physical file. Utah Admin. Code r.156-37-602(4) (2008).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Vermont	Pharmacy	VT Pharmacy regulations expressly permit e-prescribing of noncontrolled substances and controlled substances (even Schedule II drugs in limited cases). Requirements for e-prescribing include identifying the transmitter's phone number for verbal confirmation, the time and date of transmission, and the identity of the pharmacy intended to receive the transmission; and no intervening access, among others. 04-030-230 VT. Code R. § 19.3 (2009).	VT Pharmacy regulations expressly permit e-prescribing of controlled substances (even Schedule II drugs in limited cases). 04-030-230 VT. Code R. § 19.3 (2009).	VT Pharmacy regulations require that e-prescriptions, like oral prescriptions, must be "reduced to a form by the pharmacist that may be maintained for the time required." 04-030-230 VT. Code R. § 19.3 (2009). In addition, the pharmacist responsible for dispensing must provide a signed printout of each day's prescription drug order information and maintain it for 3 years. 04-030-230 VT. Code R. § 20.3.1 (2009).
Vermont	Medicaid	Medicaid payment is limited to drugs prescribed by "written prescription" or oral prescription. "Written prescription" is not defined. 13-170-008 VT. Code R. § M800 (2009).	—	—
Vermont	Food & Drug	—	Food & Drug laws on regulated drugs do not expressly address e-prescribing for controlled substances. Only address written and oral prescriptions. VT. Stat. Ann. tit.18, § 4215 (2007).	Pharmacist filling a Schedule II prescription must write the date of filling and the pharmacist's own signature on the face of the prescription. VT. Stat. Ann. tit.18, § 4215 (2007).

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Virginia	Pharmacy	VA Pharmacy regulations permit e-prescribing, consistent with federal law and Pharmacy Board regulations, but only from the prescriber directly to the dispensing pharmacy. Va. Code Ann. § 54.1-3408.02 (2008); 18 Va. Admin. Code § 110-20-285 (2008); 18 Va. Admin. Code § 110-20-10 (2008).	For electronic transmission of Schedule II-V prescriptions, transmissions must comply with any requirements of federal law. 18 Va. Admin. Code § 110-20-285(A) (2008).	If the pharmacy's automated data processing system fields are "automatically populated by an electronic transmission," the automated record may constitute the prescription and no hard copy is required. But for Schedule II–V controlled substances, storing e-prescription images instead of the hard copy is permissible only if authorized by federal law. 18 Va. Admin. Code § 110-20-250(A) (2008).
Virgin Islands	Pharmacy	VI law defines prescription as being a written or oral order. "Written" is not defined. V.I. Code Ann. tit. 27, § 141 (2008).	—	—
Virgin Islands	Food & Drug	—	Food & Drug laws do not expressly address e-prescribing. Controlled substance provisions require prescriptions for Schedule II drugs to be in writing. Those for Schedule III–IV may be written or oral. V.I. Code Ann. tit. 19, § 603(a), (b) (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Washington	Food & Drug	Food, Drug and Cosmetic law permits electronic communication of prescriptions. System used for transmitting e-prescriptions must be approved by the state board of pharmacy. Wash. Rev. Code Ann. § 69.41.055 (2008); Wash. Rev. Code Ann. § 69.41.010(10) (2008).	Uniform Controlled Substances Act (within Food & Drug code) expressly permits e-prescribing of controlled substances, limited to Schedule III–V controlled substances. Wash. Rev. Code § 69.50.312 (2008); Wash. Rev. Code § 69.50.101(cc) (2008).	—
Washington	Department of Health	The Health Department's regulations on "electronic transmission of prescription information" expressly permit e-prescribing for legend drugs and controlled substance drugs, with the exception of Schedule II drugs. Electronic transmission must comply with state and federal law. Wash. Admin. Code § 246-870-030 (2008); Wash. Admin. Code § 246-870-040 (2008); Wash. Admin. Code § 246-870-60 (2008); Wash. Admin. Code § 246-870-090 (2008); Wash. Admin. Code § 246-870-020(1) (2008).	The Health Department's regulations on "electronic transmission of prescription information" expressly permit e-prescribing for controlled substance drugs, with the exception of Schedule II drugs. Electronic transmission must comply with state and federal law. Wash. Admin. Code § 246-870-040 (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
West Virginia	Pharmacy	Code governing pharmacists expressly permits e-prescribing of noncontrolled substances. All e-prescriptions must be transmitted consistently with requirements of HIPAA, Medicare, Controlled Substances Act, and other federal laws. W. Va. Code Ann. § 30-5-12c (2008); W. Va. Code Ann. § 30-5-1b(2), (15), (16) (2008); W. Va. Code R. § 15-1-21 (2008).	WV has two pharmacy regulations relating to prescriptions for controlled substances. One regulation relates to the practice of pharmacy generally (W. Va. Code R. § 15-1-21) and the other regulation implements the Uniform Controlled Substances Act (W. Va. Code R. § 15-2-7). The two regulations accord with each other in many respects, but differ in some others: • Section 15-2-7 (7.5.1, 7.6.3) particularly specifies that a manual signature is required on a controlled substance prescription unless an exception applies. • With respect to Schedule III–V controlled substances, Section 15-2-7 (7.14.1) permits only written prescriptions signed by a prescribing practitioner or oral prescriptions. It does not expressly permit e-prescriptions, whereas § 15-1-21 (21.1.1 and 21.1.2) permits e-prescriptions for these classes of controlled substances if the pharmacist immediately reduces the prescription to a form that "may be maintained for the time period required by law." • Section 15-2-7 (7.2.1(f)) incorporates the definition of "controlled substances" found in W. Va. Code § 60A-1-101, which does not explicitly encompass "controlled substances" under the Federal Controlled Substances Act. The definition of "controlled substances" in § 15-1-2 (2.1.7) includes items deemed to be controlled substances under either the Federal Controlled Substances Act or state law.	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Wisconsin	Pharmacy	Pharmacy law recognizes e-prescribing, but only if the patient approves the transmission and the prescription order is transmitted to a pharmacy designated by the patient. Wis. Stat. Ann. § 450.11(1m), (7)(i) (2008). E-prescriptions must identify the individual sender's name and telephone number for oral confirmation; the time and date of transmission; the pharmacy intended to receive the transmission; and be designated as an "electronically transmitted prescription," or similar words or abbreviations to that effect. Wis. Admin. Code [Phar] § 7.08 (2008).	Regulations generally prohibit e-prescribing of Schedule II controlled substances, except in emergency situations, when the e-prescription must be followed with written prescription. Schedule III–V prescriptions may be renewed electronically. Wis. Admin. Code [Phar] § 7.08(1) (2008); Wis. Admin. Code [Phar] § 8.06(2)(a) (2008); Wis. Admin. Code [Phar] § 8.09 (2008).	Regulations require use of passwords to access the electronic mail system for the receipt of prescription orders. Wis. Admin. Code [Phar] § 7.08 (2008).
Wisconsin	Controlled Substances	—	Schedule II drugs generally may be dispensed only with a written prescription, except in emergency circumstances, in which case e-prescription must be reduced to writing. Schedule III or IV drugs may be dispensed with written, oral, or e-prescription. Wis. Stat. Ann. § 961.38 (2008).	—

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Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Wyoming	Pharmacy	Pharmacy regulations expressly allow e-prescribing for noncontrolled drugs. 024-059-002 Wyo. Code R. § 19(c) (2009); 024-059-002 Wyo. Code R. § 29 (2009); 024-059-002 Wyo. Code R. § 4(m) (2009).	Pharmacy regulations permit controlled substance prescriptions to be transmitted electronically only to the extent allowed by federal and Wyoming law. Expressly provide that controlled substance prescriptions may not be communicated by electronic transmission except by fax. 024-059-002 Wyo. Code R. § 19(c) (2008); 024-059-002 Wyo. Code R. § 29(f) (2008); 024-059-002 Wyo. Code R. § 20(c) (2008).	—
Wyoming	Medicaid	Medicaid regulations address written, oral, and faxed (but not e-prescriptions). They require that all prescriptions be "reduced to writing" and that certification for "medically necessary" prescriptions be in the prescribing practitioner's own handwriting. 048-130-010 Wyo. Code R. § 6(b)(ii) (2009).	—	—
Wyoming	Food & Drug/ Controlled Substances	—	Controlled Substances law expressly requires the "written prescription of a practitioner" for Schedule II drugs except in emergencies. For Schedule III or IV drugs, a written or oral prescription is required. Wyo. Stat. Ann. § 35-7-1030 (2008).	—

(continued)

Table A-1. Summaries of State Statutes and Regulations That Impact E-Prescribing* (continued)

State	Statutory or Regulatory Code	Noncontrolled Drugs Prescriptions	Controlled Drugs Prescriptions	Other (e.g., record-keeping requirements)
Wyoming	Department of Administration and Information/ Commissioner of Drugs and Substances Control —		Provisions of WY regulations appear to conflict regarding controlled substances. According to one provision, controlled substance prescriptions must be manually signed; electronic or digital signatures are prohibited. Schedule III–V controlled substance prescriptions may be faxed. 024-060-006 Wyo. Code R. § 4 (2009). However, according to another provision of the same regulation, a pharmacist may dispense a controlled substance listed in Schedules III or IV, pursuant to an electronically transmitted prescription, as well as a faxed prescription. In certain limited circumstances, Schedule II prescriptions may be faxed as well. 024-060-006 Wyo. Code R. § 21(a) (2009). Possibly, § 4 of the regulation sets standards only for hard copy prescriptions, but the provision is unclear.	—

* This table does not include summaries of the statutory/regulatory requirements for prescribing a brand name drug (e.g., a handwritten "dispense as written" or "brand necessary" notation on the prescription); those requirements are addressed in other tables included in this report.

LAHP Louisiana Association of Health Plans

January 27, 2012

Robert Marier, MD
Executive Director
Louisiana State Board of Medical Examiners
Co-Chair
Legislative Workgroup on Electronic Prescribing
P.O. Box 30250
New Orleans, LA 70190

Dear Dr. Marier:

Thank you for this opportunity to expand upon the direction of this report through additional comments. In general, LAHP supports the report's findings and recommendations; however, we would like to make three points:

1. Prior authorization programs are implemented by private and public (Medicaid and Medicare) insurers to maximize positive outcomes and reduce costs to payers, governments, employers, and patients by ensuring that when appropriate patients are treated first with lower cost, first-line therapies before progressing to newer, higher cost or experimental therapies. There are two market forces that are driving payers to increasingly adopt PA programs. First, in the last few years and looking forward through 2016 we have crossed a "patent cliff" where many heretofore blockbuster brand-name drugs are available as low cost generics for the first time because of expiring patents. On average, generic drugs cost 6-10 times less than the remaining brand products competing in that category and there is great competition being played out for provider influence between payers, governments, and patients who want lower cost drugs and branded manufacturers that want providers to prescribe higher cost medications. The second market force that is driving payers to increasingly adopt PA programs is the shift from small molecule, mass produced compounds, to large molecule, "specialty" products made through biotechnology processes. For the foreseeable future, these specialty products will make up 50-75% of FDA approvals. These drugs cost an average of $40,000 to $100,000 per patient per year, have potential uses beyond their approved labels and the payer community, large group purchasers, and re-insurers are demanding that these costly agents are being used appropriately and for their intended uses.
2. Because prior authorization is a valuable tool used by insurers to ensure their members have access to safe, affordable care and because market forces are likely to encourage the

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growth of prior authorization services, it is particularly important that electronic prior authorization standards evolve nationally without imposition of standards at the state level.

3. LAHP supports the position of prohibiting advertising in electronic medical records, electronic prescribing systems and electronic prior authorization systems. Additionally, LAHP supports the position that a prohibition on advertising should not prohibit a payer from showing the prescriber coverage information. The Committee discussed that coverage information includes any drug coverage requirements such as prior authorizations, step therapy, quantity limits, in addition to formulary alternative information. So, to the extent that developed national standards allow payers to insert comments regarding coverage information, it is beneficial to patients, providers, and payers if providers are alerted to all coverage requirements including lower cost formulary alternatives at the point of care.

Thank you for your consideration and the opportunity to provide comment on the report written by the Legislative Workgroup on Electronic Prescribing and Electronic Prior Authorization.

Sincerely,

Milam Ford, B.S. Pharm., MBA, MPH
Vice President, Pharmacy Services
Blue Cross and Blue Shield of Louisiana

cc: Malcolm J Broussard
Executive Director
Louisiana Board of Pharmacy

Gil Dupré
Chief Executive Officer
Louisiana Association of Health Plans

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TO: Robert L. Marier, MD
Malcolm J. Broussard

FROM: Cindy Munn, Executive Director

RE: SR 81/HR 108 (2011) – Legislative Workgroup on Electronic Prescribing and Electronic Prior Authorization

DATE: January 27, 2012

On behalf of the Louisiana Health Care Quality Forum, I am writing in support of the **Legislative Workgroup Report on Electronic Prescribing and Electronic Prior Authorization.** In addition, I would like to share our comments on the final report and reiterate the organization's support to assist this workgroup.

The Forum is a private, not-for-profit organization dedicated to advancing evidence-based, collaborative initiatives to improve the health of Louisiana residents. As a multi-stakeholder improvement organization, it is well-positioned to serve as a neutral convener of providers, payers, consumers and purchasers. It also serves as the state-designated entity to lead the planning and implementation of Louisiana's regional extension center and health information exchange.

The Louisiana Health Information Exchange, or LaHIE, allows authorized providers and organizations to electronically access and share health-related information through a secure and confidential network to improve patient safety, quality of care and health outcomes. The exchange is currently being implemented statewide.

In relation to Section II, B4, discussion at the workgroup meeting on Jan. 18, 2012, focused on standardization of electronic prior authorization to meet the needs of providers, insurers and pharmacy benefit managers. At this time, we do not know when national standards for electronic prior authorization will be announced, but the Forum offers its services as a neutral facilitator to convene representatives from these groups at the state level to discuss mutually acceptable solutions.

In closing, the Forum is prepared to work closely with all member organizations that comprise this workgroup. We will ensure that state-level issues about electronic prescribing and electronic prior authorization are relayed to the Office of the National Coordinator for Health Information Technology and are used to potentially shape national policy. Likewise, the Forum will communicate the latest information from the national health IT agenda within the state to facilitate alignment of these issues.

eQ·Health solutions

January 30, 2012

Robert L. Marier, MD
Louisiana State Board of Medical Examiners
P.O. Box 30250
New Orleans, LA 70190-0250

Re: eQHealth Solutions' Comments for the Legislative Workgroup on E-Prescribing

Dear Dr. Marier:

eQHealth Solutions is a not-for-profit, physician sponsored health care organization operating in Louisiana, Illinois, Florida and Mississippi. It has served as the Louisiana Medicare Quality Improvement Organization (QIO) since 1986. The QIO Program is delivered locally through a national network of 53 independent QIOs under the direction of the Centers for Medicare & Medicaid Services (CMS). The QIO Program brings evidence-based best practices to the bedside, with the flexibility to respond to local needs.

Our objective is to improve the value of health care services delivered to Medicare beneficiaries in Louisiana. We do this by helping health care providers (physicians, extenders, hospitals, nursing homes and others) align care processes with national standards that are evidence-based and clearly linked to better patient outcomes. Because our work focuses on many common diagnoses and procedures, both in acute and long term care settings, QIO activities benefit all patients regardless of insurance or payer status.

Within the healthcare community, eQHS has assisted physicians with adoption of electronic health records (EHR) including the ability to E-Prescribe. In previous scopes of work or CMS initiatives, as well as our ongoing efforts in Health Information Technology (HIT) and prior DOQ-IT experience, eQHS has provided needed assistance in the selection, adoption, and implementation of HIT to more than 300 Louisiana physicians statewide. Drs. Edwin R. Bonilla and Chris Granger of the Family Health Clinic in DeRidder, Louisiana became the very first physicians in Louisiana and the seventh in the nation to successfully submit quality data electronically to the Doctor's Office Quality - Information Technology (DOQ-IT) data warehouse in 2007 with the help of eQHeath Solutions Quality Improvement Specialists. We have also worked to improve health outcomes for disparate populations in Louisiana in order to reduce the higher health burden of diabetics on racial and ethnic minorities and have improved the reporting of core preventive measures in patient populations by physicians.

In our continuing effort to support physician quality improvement activities, eQHS is currently assisting a select group of primary care physicians with qualified EHRs who are participating in the Physician Quality Reporting System (PQRS) program. Individual eligible professionals who meet the criteria for satisfactory submission of Physician Quality Reporting quality measures data via one of the reporting mechanisms above for services furnished during a 2011 reporting period will qualify to earn a Physician Quality Reporting incentive payment equal to 1.0% of their total estimated Medicare Part B Physician

Fee Schedule (PFS) allowed charges for covered professional services furnished during that same reporting period.

Lessons learned through our work with these physician practices will be made available to at no charge to all physicians and interested stakeholders state-wide. We are now launching shared learning platforms including Learning and Action Networks (LANs). LAN participants will be drawn from all relevant settings including government agencies, educational institutions, private sector and direct care providers who will meet face-to-face and via virtual collaboration tools to share learning. By becoming contributors as well as consumers of learning, LAN participants are optimally positioned to spread indigenous quality improvement best practices.

eQHS will also work within other current initiatives to help identify and reduce Adverse Drug Events (ADEs) in particular in Patient Safety and Clinical Pharmacy Services Collaborative (PSPC). By such effort, these PSPC communities can achieve optimal health outcomes, thus preventing and eliminating potentially preventable patient harm in patients over the age of 65 years. Secondary benefit will be measured in the form of reduced emergency room (ER) visits and reduced hospital admissions and readmissions where the primary or secondary diagnosis is an ADE.

Further comments in regard specifically to E-Prescribing by providers include the following:
There are electronic systems for E-Prescribing available to providers yet many are not part of certified or qualified EHRs. Some systems are more sophisticated than others and despite a need for perfection, few meet that definition. Despite current Computerized Physician Order Entry (CPOE), system failures are known to occur; it is not a panacea. Koppel reported in the JAMA (2005) that CPOE is associated with 22 types of error risks due to poorly designed or poorly implemented systems. It has been reported that 75% of ADEs resulted from system failures and all errors could have been reduced by better information systems.

Even having a CPOE within a hospital setting, there can remain a risk for patient safety. Not many are connected to the entire electronic medical record (EMR) of each patient so that data in one system may not be known to the other, an innovation promised but yet to be delivered.

A system is defined as a set of interacting, integrated, or interdependent elements that work together in a particular environment to achieve a specific aim; in our workgroup discussion and directives, the aim is E-Prescribing, patient safety and patient care, and prior authorization of prescribed medications.
An essential need for future healthcare systems in Louisiana is to be interrelated and connected – from physician/provider office practices, ambulatory care facilities, and inpatient hospitals to home health care agencies, laboratory/diagnostics venues and pharmacies. This will require a sophistication of electronic systems yet to be achieved by most systems currently available.

Any weak link in the processing for a patient can cause a failure in the procurement of a correct, safe and prompt prescription. It will take all steps in the E-Prescribing process to function to assure the patient is best served.

Some provider practices that early on instituted an E-Prescribing system may find that later connecting to a different EMR system can be costly or impossible to accomplish, perpetuating the disconnect between current patient data and prescribing decisions. This is a provider concern and a patient safety issue.

In regards to Prior Authorization (PAu) for a patient's needed medication, the provider should be prepared to always advocate for their patient. Physicians and other prescribers will continually be called on to help patients traverse the shifting, ever changing prescribing policy terrain safely and successfully. Many patients may prefer to pay for improper foods, tobacco products, alcohol, pain pills and tranquilizers rather than preventive and chronic disease control medications essential for their health. For whatever reason, the very patient that needs particular medications to prevent health deterioration, crises, or death will not afford such or be able to afford the co-payments. The resulting cost of healthcare for that patient may far exceed the cost of medications they did not receive.

The inconvenience of PAu could prompt providers and patients to forgo the use of effective, appropriate, and safer drugs. The impact of PAu on the cost of health care is not known. It may offer savings and profit for payers in the short term, but bring about less than optimal clinical outcomes long-term and a reduced quality of life issue for patients.

The way in which PAu programs are designed and administered is likely to make a critical difference in their effectiveness and acceptability to the provider and the patient. When preferred lists are developed thoughtfully and based entirely on accepted clinical evidence, they can guide the clinicians to select the cheaper of equally effective drugs. The extra time required to refer to the preferred list for that payer before initiating a new prescription (Rx) for the patient is modest and time-saving compared to sending a prescription to pharmacy that is subsequently rejected for failure to be covered, not to mention the time lost having to later open the patient's EMR to choose an alternative. However, choosing medications that will better benefit a particular patient must be dictated by what is best for that particular patient and based of quality outcomes measures and not on cost alone.

Not all Medicare Part D or Part C plans are the same. Patients must choose once yearly which plan will cover their current medications and hope that these medications will not change in the coming 12 months due to progression of their illnesses or complications. Many payers and their prescription benefit management programs (PBM) may change preferred name brands or generic alternatives of drugs whenever improved costs are of benefit to them. New evidence of potential harm to patients by prescribed drugs may necessitate a change in formularies either to a higher tiered drug or one not covered by the patient's plan. This, however, requires more provider time and decision-making often not covered by payer and may not be afforded by the patient. These formulary changes for whatever reason could impact patient costs until a new payer or plan can be chosen by the patient or reaching the "doughnut hole" under Medicare Part D sooner.

PAu may require documentation by provider of step-by-step use of alternatives prior to approving a brand name or non-covered drug. If approved, limits maybe set on the number of pills prescribed. To accomplish electronic prior authorization (ePAu) is a noble goal and could be helpful for both providers and patients. But if by doing so, coverage of particular drugs are not approved or allowed, there needs to be in place mechanisms to promptly dictate and to help accomplish appeal mechanisms. To have a human-to-human interaction for the benefit of the patient and his/her medical needs based on best practice and evidence-based data will be essential beyond the ePAu. Appeal discussions between patient's attending physicians with the physician medical director of the payer should be allowed to discuss what is best for that particular patient. Physicians are the primary advocate for patients and must be included in the decision-making process at the beginning and not at the end of the process of drug selection.

Thank you for allowing eQHealth Solutions the opportunity to present our comments for the Legislative Workgroup on E-Prescribing as proscribed by Senate Resolution 81 of the 2011 Legislature.

Sincerely,

Trenton L. James, MD
Associate Medical Director of the QIO for Louisiana